WINTER 1974

THE MEANING OF EMOTIONAL MATURITY

PSYCHOSURGERY ON CHILDREN

INTERVIEW WITH "BUZZ" ALDRIN

LEGAL ADVICE FOR PSYCHIATRISTS

MENTAL HEALTH AND POPULATION CONTROL

THE FUTURE OF RESEARCH

Winter 1974 • Volume 58, Number 1

CONTENTS

4 "BUZZ" ALDRIN: I'VE BEEN THERE—interview

6 RESEARCH STILL HOLDS THE ANSWER—article
SEYMOUR S. KETY, M.D.

9 EMOTIONAL MATURITY—article
WALTER S. SMITSON, D.S.W.

12 MENTAL HEALTH AND POPULATION CONTROL—article
EUGENE B. BRODY, M.D.

15 IMAGES—essay
BILL PERRY, JR.

19 UNDERLYING A METHOD—article
PHYLLIS BREGGIN

22 NAMH ON PSYCHOSURGERY—position

24 LEGAL ADVICE FOR PSYCHIATRISTS—article
DONALD J. DAWIDOFF, L.L.B.

DEPARTMENTS

2 LETTERS

3 COMMENTARY

26 BOOKS

30 NOTES

32 PUBLICATIONS

After more than 50 years as a journal devoted principally to exchange among mental health professionals, **MH (Mental Hygiene)** in 1970 began a transition to become a publication designed for policymakers—both lay and professional—in the mental health field. The Board of Directors believes that other journals now provide effective exchange within professions and among professionals, but no regular publication exists to inform the growing number of citizens faced with major policy decisions involving future care systems and prevention. We believe that our new focus will help stimulate activity in the development and improvement of health care delivery systems and contribute to improved care and prevention efforts.

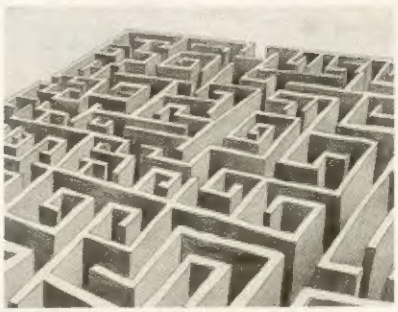
MH is published quarterly by the Communication Department of the National Association for Mental Health, Inc. Editorial Office: 1800 North Kent St., Rosslyn, Arlington, Va. 22209. Circulation Department: 49 Sheridan Ave., Albany, N.Y. 12210. Rates: $10 per year (Canada, $10.25; other countries, $10.50). Single copy, $3.

The National Association for Mental Health does not necessarily endorse or assume responsibility for opinions expressed or statements made in signed articles, nor does the reviewing of a book imply its recommendation by NAMH.

Printed in Baltimore, Md. Second class postage paid at Albany, N.Y., and additional entry office.

Aldrin 4

Research 6



Film 15

Method 19

Credits:
Cover, 19, 22, 40—H. Armstrong Roberts; *6, 12, 24*—Day Walters Photographic Illustration; *9*—Daly City Record (Courtesy of San Mateo MHA); *15*—Courtesy of Imagination, Inc., San Francisco; *16, 17, 18*—John Thomas.

MOVING? PLEASE NOTIFY US 4 WEEKS IN ADVANCE

Attach mailing label here, fill in new address below and send to: MH SUBSCRIPTION OFFICE, 49 Sheridan Ave., Albany, N.Y. 12210.

Name_____

New Address _____

City_____ State_____ Zip_____

TO WRITE ABOUT YOUR SUBSCRIPTION: Change of address, billing adjustment, complaint, renewal—address: MH SUBSCRIPTION OFFICE, 49 Sheridan Ave., Albany, N.Y. 12210. (Attach present address label in space provided. If you are receiving duplicate copies, please attach both labels.) This will help us identify you quickly and accurately.

TO ORDER A NEW SUBSCRIPTION: Check box ☐ and use form above. Mail to MH SUBSCRIPTION OFFICE at the address given. Or for faster service and attention, you can simply call (518) 436-9686. Subscription rate: U.S., 1 year $10.00; in Canada, $10.25; other countries, $10.50.

TO WRITE ABOUT EDITORIAL CONTENTS: Address: MH, 1800 N. Kent St., Arlington, Va. 22209.

LETTERS

GOOD READING

Dear Sir:

I want to congratulate you on the format and contents of MH. It is the only magazine I receive that I read every article. The one (*The Party*, Summer MH) by Bernard Posner was exceptionally good.

ROBERT L. HUFFMAN
Executive Director
The Toby House
Phoenix, Ariz. 85003

PRISON REACTION

Dear Sir:

The edition (on prison) raises some interesting questions about several aspects of correctional reform and will undoubtedly be of value to your readers.

NORMAN A. CARLSON
Director, Bureau of Prisons
Washington, D.C. 20537

Dear Sir:

We understand that your issue in the fall was on prisons. This we are told was a very fine issue and had good articles. Please send us two copies and bill us.

COL. EARL C. GRANDSTAFF, D.C.
Coordinator, Administration of Justice Studies
Culver-Stockton College
Canton, Mo. 63435

Dear Sir:

Just a word of thanks for the splendid job that you and your associates did with our *From Within* prison art story in the mental health quarterly. It really was quite beautiful, and I appreciate it.

WILLIAM RUDER
Principal, Ruder & Finn, Inc.
New York, N.Y. 10022

Dear Sir:

The article, *The Forgotten Victim*, will concern me very much as I am now trying to set up an organization in Texas to help the families of men in prison. We call it the Society of St. Stephen.

The Society of St. Stephen hopefully will be organized in every Methodist Church and will help families in need. One of the emphases we are placing on the Societies is to locate in the community the families of men who are confined in the Texas Department of Corrections. The Society will try to help them in any way they can and also provide transportation from their home to the prison on a regular basis.

WOODROW SEALS
U.S. District Judge
Houston, Tex. 77061

COMMENTARY

Richard C. Allen, Editor-in-Chief

In the Summer 1972 issue of MH, we published an article on the *right to treatment* case in Alabama, *Wyatt v. Stickney*, in which a United States District Court judge issued an order detailing the minimum Constitutional requirements for the care and treatment of mental patients and residents of state schools for the retarded. The decision has been appealed by Governor Wallace, and is under advisement by the United States Court of Appeals for the Fifth Circuit. It is now entitled *Wyatt v. Aderholdt*, Dr. Stonewall B. Stickney having been replaced as commissioner of mental health while the case was in the process of appeal.

You may remember in that issue's *Commentary*, I said that such suits were not attacks on the superintendents of places like Partlow State School and Bryce Hospital (and there are many of them around the country), but rather they should be regarded by them as establishing a new alliance to attain our common goals of improved mental health care facilities, which treat instead of warehouse their residents. Apparently Dr. Stickney saw it just that way. He is quoted in a recent issue of PSYCHIATRIC NEWS as follows:

> *Our biggest problem . . . was how to lose gracefully. The only way we could win was at the expense of the patients, because we felt we had pretty well exhausted our efforts to get sufficient money from the legislature . . . We felt our only hope was to bring this to court, so we more or less surreptitiously took sides with the court, and only defended what we thought was truly defensible . . . which led the governor and some of our other critics to say that we rolled over and played dead.*

But Governor Wallace calls the shots in Alabama, and now Dr. Stickney is gone. Meanwhile, the appeal drags on, and it is the patients who suffer. However, a decision from the Court of Appeals, or from the Supreme Court, will have far greater impact than a District Court decision, and it seems inconceivable that Judge Johnson will be reversed. We will keep you advised of developments.

Another governor, Ronald Reagan of California, is *changing things* in the institutions of his state—not by improving standards of care, but by closing mental hospitals and institutions for the retarded! In 1955 there were 50,000 such patients, but today there are less than 7,000. All state hospitals for the mentally ill have been scheduled to be closed by 1977, and all state institutions for the retarded by 1981. However, plans just announced appear to have extended those dates.

□

Where are the former residents of California's hospitals and schools for the retarded? Well, some of them—a considerable number—are in jails. For instance, an official of the Santa Clara County Sheriff's Department reports that their jail population has more than tripled, because of the addition of former mental patients, picked up for *loitering* or *mischievous conduct*. Others are awaiting trial for more serious crimes, more than 70 have taken their own lives, and many are on welfare. But the governor is making a record on cutting hospital costs, which should serve him well in his quest for the Presidency in 1976!

I am sure you have noted the action of the American Psychiatric Association in deleting homosexuality from its compendium of mental disorders. Thus, in one great medical *breakthrough*, some 12,000,000 formerly *sick* citizens have become *well*—by fiat. Seriously, though, A.P.A.'s having joined A.M.A. in seeking repeal of state laws which make private acts between consenting adults criminal, should have a powerful and positive impact.

Also encouraging is a brief filed in a case involving residents of Alabama's Partlow School, by the Department of Justice, urging that no mentally retarded resident should be sterilized without: first, a finding that the patient would not be helped by less drastic contraceptive measures, such as birth control pills; and, second, the patient's adequate and informed consent. Under the proposed guidelines, no sterilization could be performed unless a review committee has certified to both requirements, with the resident represented throughout the review by lay or legal counsel, and with a written record of the proceedings. ■

EDWIN E. "BUZZ" ALDRIN: I'VE BEEN THERE

On July 20, 1969, Colonel Edwin E. "Buzz" Aldrin became one of the first two men to set foot on the moon. After that celebrated landing, he returned to earth a hero, only to suffer a severe emotional illness. His best-selling autobiography, Return to Earth, *describes his recurrent bouts of "depression alternating with emotional highs."*

These extreme mood swings finally incapacitated him to the point where he was hospitalized. While under treatment, Aldrin came to understand what was wrong with him: he had spent most of his life competing for difficult goals and now with the moonwalk behind him, he was suffering from "the melancholy of all things done." By the time he left the hospital, he was able to look forward instead of back and to plan a new life instead of floundering without purpose in past triumphs.

Aldrin said he wrote the book because "it is my wish to bring the once taboo subject of emotional illness into the open so that it can be faced and treated the way a physical infirmity is."

Early in 1972, following 21 years of service, the 43-year-old Montclair, N.J., native retired from the Air Force to form his own consulting firm. During that time, he was awarded the Presidential Medal for Freedom, numerous military medals, and the highest decorations that can be bestowed on an individual by 11 other nations. He is a graduate of the United States Military Academy at West Point and holds a Doctor of Science degree from the Massachusetts Institute of Technology. Today, Aldrin, his wife, Joan, and their three children live in a rambling ranch house in California's San Fernando Valley.

A member of the NAMH *Board of Directors, he was named this past November as the 1974 National Mental Health Chairman. In this role, he will attempt to reach as many people as possible to help dispel the myths and misconceptions surrounding mental illness and the mentally ill.*

MH: Why is it so hard for people to understand depression?

ALDRIN: Well, for one thing, not everyone can identify with it the same way. For instance, you may have a different set of circumstances *bugging* you than what's bothering somebody else. Or you may react differently to the same set of circumstances than another person. Your techniques for coming out of depression may also vary . . . the same ones don't always work the same way the second time around. Maybe you don't know what moves you out of a depressed state, but the last thing you want to do is dwell too much on why it's happening. Otherwise, it may come back.

MH: How does a person know when it's depression and not just a temporary period?

ALDRIN: If you're comparing *blues* to depression, they don't mean the same thing. By that I mean you can't multiply one bad day by 30 and call that depression. The signs are highly individualistic. In my own case, they were undue anxiety, forgetfulness, and indecision.

MH: Why is it hard for a person to overcome depression himself?

ALDRIN: Primarily because it's a self-perpetuating thing. A paralysis of action sets in, and you just have a desire to avoid making decisions.

MH: What is the greatest drawback to a person seeking help for depression?

ALDRIN: I think it's the inherent hesitancy to admit you sometimes need to sort things out with the help of a professional. You see, everybody will admit making certain mistakes in their lives, but few will label these as *errors of judgment*. The line of reasoning seems to be if you admit to poor judgment that's akin to *thinking* you have problems. Surprisingly, many people hold that viewpoint—even depressives. They just don't want to admit that they've made a thinking error.

MH: That being the case, what can an individual do to overcome this *roadblock* to getting treatment?

ALDRIN: The biggest thing is to admit and accept the fact that you're going to do it. Believe it or not, there's a great deal of therapeutic value in that.

MH: Who should an individual turn to for help first?

ALDRIN: Again, I'm speaking from my own experience, but early in the process, my wife was aware of what was going on. Also, I was in contact with people close to me everyday, and it was always helpful to talk things out. Prior to my seeking help, I sought advice from many contemporaries. This wasn't entirely satisfactory, maybe because they didn't know how to help nor should they have been expected to. When you can convince yourself to seek counseling, you do it with the knowledge that there's nothing better available. Then you have to couple that with faith and make it work for you.

MH: What should a person who seeks treatment expect?

ALDRIN: This is a highly individualistic thing we're talking about. But I would venture to say that this person should approach the treatment with optimism that his ultimate chances for a cure are good. In my own case, there's never been any doubt about my doing the right thing.

A candid interview with this year's National Mental Health Chairman

MH: From your bout with depression, how do you avoid a possible recurrence?

ALDRIN: You've got to learn to live with it just like a stomach cramp . . . and continually set up *defenses* against it. This, I've found, means being aware of its cyclic potential. It also means being able to control living conditions that start to develop—such things as anxiety-causing conflicts.

MH: How universal is depression—I mean here you are, a man who's been to the moon and all, it's understandable the pressures you were under—but what about *the man on the street*?

ALDRIN: A good question. I think it's all a matter of degrees and what's relevant to the individual. The pressures on the average person are just as real as they are on the astronaut or anybody else in the public eye . . . and they all can result in the same thing.

MH: What do you think of a *Depressives Anonymous* similar to *Alcoholics Anonymous*?

ALDRIN: That's an interesting idea, but I'm not sure whether it would work. I say that because the solution is not as simple for the depressive as it is for the alcoholic. With Alcoholics Anonymous, each person understands what the other is going through. And the solution is simple: stop drinking. The alcoholic realizes this, but generally doesn't want to be lectured to by a doctor. Consequently, he gets sympathy from former AA members. The same, of course, could hold true for the depressed person, except that the individual nature of each person's depression would not lend itself to as neat a solution, because you've got to get down to specifics and talk it out with a professional. ■

By Seymour S. Kety, M.D.

A little more than 10 years ago, it was generally accepted that psychiatric research would ultimately give us the answers we are seeking in the area of mental health. Today, however, the situation is considerably different.

To see what has happened to the hopes, the aspirations, and the promises of that research, let's trace its history over the past 25 years in which I've been engaged in it.

Prior to this time, we witnessed the rapid ascendancy of research as a crucial component of medicine, pediatrics, and even surgery. As such, it became an important consideration in training and the appointments of new professors. It also converted medicine from an empirical art to a scientific body of knowledge which was responsible for eradicating many of the diseases that plagued our elders.

Psychiatric research started later, receiving a great impetus from the National Mental Health Act of 1946. This established the National Institute of Mental Health (NIMH) to support and carry out research toward a better understanding of mental illness and its diagnosis, treatment, and prevention. The Institute's intramural research program began to achieve recognition as an important center of psychiatric research, while its extramural program rapidly became the stimulus and support for a broad and expanding research effort into the mysteries of the brain and behavior.

The growth phase of that effort went on for 20 years at a cost which was trifling compared with what we were spending at that time for tobacco, alcohol, and even chewing gum. For what I have estimated to be 20¢ per year for each American, we bought, during those years, a greater understanding of the brain and behavior than civilized man had achieved in 50 centuries.

At the end of this period, the

Dr. Kety is Professor of Psychiatry, Harvard Medical School, and Director, Psychiatric Research Laboratories, Massachusetts General Hospital. He is also a past recipient of the Mental Health Association Research Achievement Award.

growth curve leveled off, simultaneously with that of the entire biomedical research effort. And such a curtailment will undoubtedly prove to be critical for psychiatry.

I say this because, 10 years ago, many of us saw the practice coming into its own as an important branch of medicine and applied behavioral science—resting upon a substantial scientific foundation, challenging dogma, critically testing hypotheses, evaluating old and new therapies, discarding those that are not effective, and improving those that are.

Needless to say, 20 years were just not enough for psychiatric research to vigorously mature. There is cause for concern that its development may have been prematurely arrested, and that a forced obsolescence is affecting such research and its value to the field today. However, the reasons for this lie largely outside the National Institute of Mental Health which has, to a considerable extent, managed to resist a number of pressures which have been placed on it. The reasons are not even confined to the Federal government, which can argue that it is merely responding to the national mood.

Indeed, one sees ample evidence for such a mood in many quarters. Most of the state governments, which have traditionally supported psychiatric research, have leveled off or cut back their appropriations even more severely than has occurred in NIMH. With a few notable exceptions, private foundations, which formerly recognized the long term amplification that limited funds would find in research, have turned to more immediately relevant activities. Citizens' groups have been more concerned with coordinating, monitoring, and even attacking research than in supporting it.

The reasons for this waning of public enthusiasm are manifold. Many stem from an appropriate, if belated, concern about serious national problems of poverty, malnutrition, inequality of opportunity, maldistribution of health services, and a divisive and debilitating way. Though tremendously important, all of these range far beyond the ability of biomedical or psychiatric research to redress. Yet, our wish to relieve those problems that need relief has often been needlessly at the expense of research.

For instance, disenchantment and hostility, which may have started against nuclear physics for allowing itself to be used in the development of the atom bomb, has quickly spread to other research, including the biomedical and psychiatric efforts.

On the unsubstantiated assumption that mental illness is a myth or that its roots are to be found entirely in the social system, some will argue that research into this area is denigrated or self-serving. Still others fear that support of research diverts a significant fraction of money and manpower from unfulfilled national needs in health care.

THESE and similar concerns prompted many foundations to turn their efforts from research to health care. Yet, a comparison of the relative costs and magnitudes fails to support this argument. Adequate health care for all segments of the American population will cost in the neighborhood of $70 billion annually. It is urgently needed and can only be met with a more sensitive distribution of our national priorities.

However, we cannot hope to make much of a dent in that $70 billion by even the most drastic cutbacks in the $2 billion that we now spend in toto for biomedical research. To provide that care, this nation will require a considerable increase in the present number of graduates of medicine and the allied disciplines.

It is unrealistic to think that we can get that manpower by cutting back on the 2 or 3 percent of these graduates who make careers in full-time research. Similarly, the total cost of research in psychiatry, and in the brain and behavior—including that supported by Federal, state and private sources—is no more than a few percent of what we pay for the care of the mentally ill. It's also negligible in comparison with the estimated $20 billion annual cost of mental illness in this country.

Finally, there are those who recognize the value of research but are impatient with the apparently slow and often mysterious processes by which the results come forth. Like the king who owned a goose that laid golden eggs, they would like to accelerate the rate of production without trying to understand it. The implication is that scientists have had a preoccupation with research for its own sake, a disinterest in applying basic information to clinical or public health problems. Or they have failed to marshal their resources toward directed attacks on the most killing or disabling diseases, permitting life-saving discoveries to lie fallow in the laboratories.

Since their emergence 20 years ago, the National Institutes of Health have developed and striven to maintain a philosophy of direction and support in which scientific excellence and feasibility were the important guidelines. During the same period of time, the American medical research community became preeminent throughout the world in terms of productive people, papers published, foreign fellows who sought to train here, the number of Nobel prizes won in medicine and physiology, and in the sheer number of substantive contributions to health and clinical problems. Consequently, it is difficult to see why one would want to tamper with so successful a process.

Nevertheless, the press tends to play up the spectacular breakthrough rather than the laborious accumulation of knowledge on which it was based. Also emphasizing this imminent payoff has been the testimony before Congressional appropriations committees by well-intentioned laymen, scientists and, sometimes, directors of the various institutes.

With regard to research on the major mental illnesses, it is now more promising than ever before. The polarization between genetic and environmental contributions to mental illness has diminished and

means exist for examining what is genetically transmitted and what specific environmental factors are necessary to produce or protect against mental illness in a vulnerable individual.

Drugs have been developed, particularly for schizophrenia and depression and, despite some undesirable side effects, they have produced a considerable change in the prognosis and prospects for treatment of people afflicted with these illnesses. Even more important than that, these drugs, combined with new knowledge, have given us, for the first time, insights into the mechanisms by which they may act and the processes that may lie at the root of these illnesses. I am referring to certain neurochemical aspects of the brain, like the catecholamine system in which there has been a great spurt in our knowledge over the past decade.

Ten years ago, a system containing one of the catecholamines—dopamine—was discovered in the brain and since that time, the pathways that contain, synthesize and use dopamine throughout the brain have been elucidated. That basic information led directly to the development of the l-dopa treatment of Parkinson's disease. But more interesting to us is the possibility that it may also be involved in schizophrenia.

The drugs that are most effective in the treatment of schizophrenia belong to two quite distinct chemical families. A troublesome side effect of the use of these drugs has been the appearance of symptoms similar to those that are seen in Parkinson's disease. When the importance of dopamine was recognized in that illness, attention turned to the possibility that these drugs may be acting on schizophrenia through the dopamine system of the brain. In recent years, it has been established that these drugs do, in fact, carry out an important action upon that system.

Equally significant is the fact that all of the drugs that can produce a toxic psychosis, amphetamine stands out because the psychosis it produces is so much like schizophrenia that it is often confused with it. An important action of amphetamine is also upon the dopamine system of the brain.

I find it had to believe that this drug, which can mimic schizophrenia, and the drugs that can treat it effectively all converge on the dopamine system by sheer coincidence. I think it is very likely that these drugs exert their mental and behavioral effects through this catecholamine system. I also think these recent findings are telling us something about what may be disordered in schizophrenia. For the first time, we seem to have a clear picture of one area of basic research that would be worth cultivating for its possible contribution to an understanding of a major mental illness.

ONE can see the other pieces of recently acquired information fitting together in the puzzle and new techniques that will enable scientists to eventually give us a solution. All in all, I am more encouraged about the prospects for research and its contribution to the major mental illnesses than I have ever been before.

Mental health is a field of such concern to society and so intellectually challenging to scientists that there is the strongest motivation for each to contribute with his most vigorous efforts and in the way he knows best. The fundamental aspects of biology and behavior continue to attract a substantial number of creative minds to their complex problems.

There is an increasing number of clinical scientists, well-trained in basic sciences and in clinical research, and a large number of research laboratories in the pharmaceutical field and other industries eager to contribute to these clinical problems. That kind of daily preoccupation on their part is the best way I know of utilizing knowledge without cutting off its supply.

Clearly, the research most relevant to a particular problem is that which will be necessary for its solution. That judgment, however, can only be made with certainty in retrospect. What inevitably emerges from an analysis of the great discoveries of the past is a recognition that had each truly relevant and crucial contribution been forced to meet a narrow or superficial interpretation of relevance or to receive popular approval, the ultimate discovery would not have been made.

There is an important guideline and an important conviction that most scientists share—that being, it is good to support creative minds in accumulating fundamental knowledge and homing in on a target that scientific judgment indicates is feasible. It is good, not because scientists have a right to satisfy their curiosity at public expense, but because it is the most practical and efficient way to utilize our limited scientific and financial resources for the greatest social benefit. It is not difficult to see how the public can shortchange itself by insisting that relevance which it can appreciate take precedence over the criteria available in competent scientific review, which guarantees that public funds be spent on competent, plausible and reliable research rather than illusory and premature claims.

If the custodians of public funds use them for easily justified projects of conspicuous relevance, they will not really be meeting their responsibilities. On the other hand, if they ask for and receive the advice of the most creative and critical minds, and, together with these, seek out every possible relevance, the most qualified and reliable investigators, the research most likely to serve as the foundation of knowledge as well as its culmination, they will have bought the best and the most effective programs.

There are still several million Americans—repesenting every color, creed and class—who are confined to mental hospitals or compromised in their ability to lead a productive and rewarding life by mental illness. True, we do not *yet* know all the answers behind this crippler, but research can give them to us. There just is no effective shortcut. ■

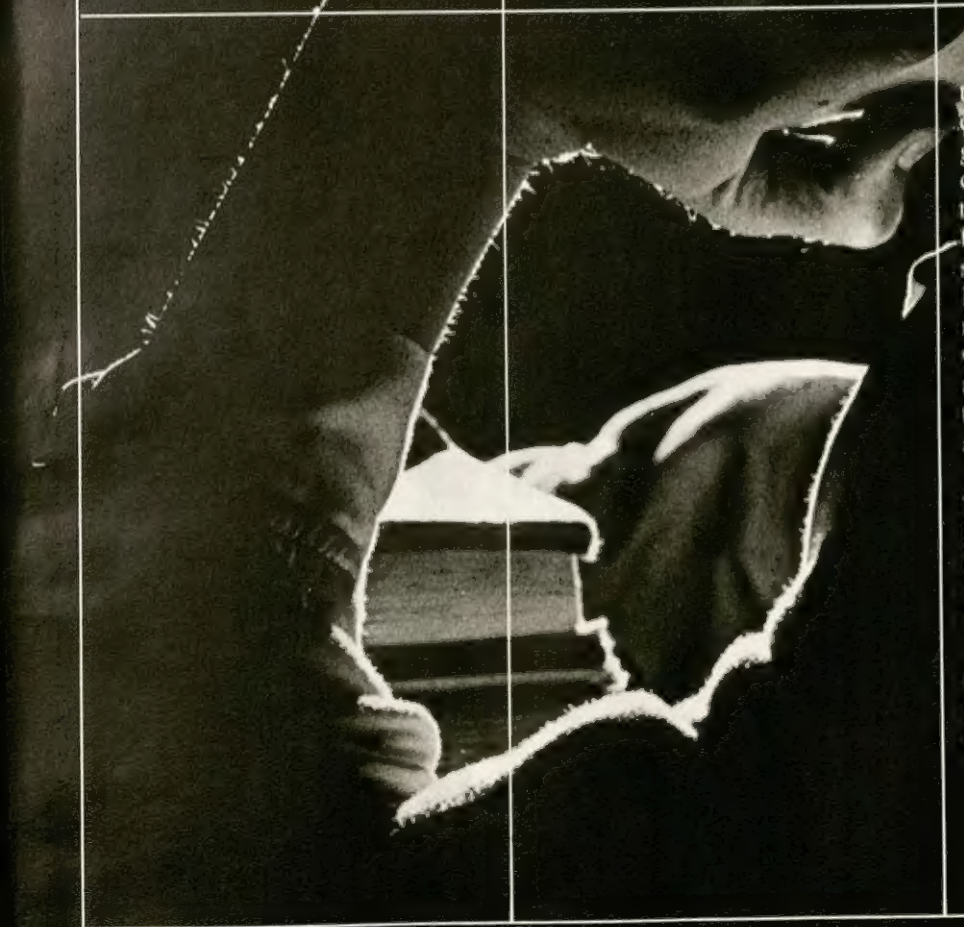
The Meaning of Emotional Maturity

By Walter S. Smitson, D.S.W.

KNOWING the direction to emotional maturity provides the basis for an inner security, for an understanding of oneself and others, and for full and productive interpersonal relationships. Yet, finding this direction proves to be an elusive experience for many.

The elusiveness is, in part, due to the abstract nature of emotional maturity along with the fact that it is not a static condition. Instead, emotional maturity is a process in which the personality is continually striving for a greater sense of emotional health, both intrapsychically and interpersonally. It is an attitude, a direction, never a destination.

We all experience fluctuation in our emotional states and in our interpersonal relationships. Periodically, for minutes, hours, days, or weeks we are unable to live up to the standards we have established for ourselves. Such sub-standard behavior should be considered normal and, therefore, should not become reason for self-imposed, harsh criticism or a feeling that on that basis alone one is immature.



ON the other hand, if substandard behavior becomes a pattern, or a way of life, it is reason for concern, and thought should be given to ways of eliminating such counterproductive action. Corrections of immature behavior can often be made through increased self-observations and self-understanding. Insight can also be obtained through reading, learning to observe others with objectivity, increasing one's awareness of non-verbal cues, and through counseling or psychotherapy.

Such insight sets the foundation for making course corrections of intrapsychic and interpersonal behavior. More serious patterns of maladaptative behavior such as neurosis, character problems, and psychosis signify the personalities' strong preference for regressive reactions and, therefore, indicates a need for professional treatment.

Dr. Smitson is Acting Director of the Central Psychiatric Clinic; Professor and Director of Psychiatric Social Work, Department of Psychiatry, University of Cincinnati Medical School.

TOWARD INDEPENDENCE. Everyone comes into the world totally on the receiving end, and some never change that position throughout their stay. The experiences of the infant and small child create a strong desire for a pleasure-oriented, *I want what I want when I want it* type of life.

Much of the struggle of adolescence pertains to the conflict between the drive for emotional maturity involving an increased capacity to take charge of one's life and the counter force of wanting to look continually to others to make one's life good. If the child continues too long in a dependent position, or if he misses too much of it, his normal progression toward full emotional independence is impaired.

The complex drawn-out relationship between child and parents greatly contributes to the difficulties humans in our society have in achieving independence. The tendency of many parents to hold on to their children, to relive their lives through their children, and to over-protect their children greatly complicates the natural progression toward independence. Some youngsters never overcome these handicaps and, consequently, physically grow up only to remain emotionally dependent children trying to imitate adults.

ABILITY TO ACCEPT REALITY. Reality can be simply defined as the world we live in, with all its strengths and weaknesses, its joys, its satisfactions, and its contentments. Likewise, it includes the emotional hurts, the hostilities, the lack of understanding, the dishonesty, the disappointments, and the losses. The crucial issue for each of us is whether we acknowledge all these aspects of reality or deny them and take flight.

Mental hospitals are full of persons who have long histories of trying to run away from reality. Such persons may begin the denial-of-reality pattern by momentary escapes, such as unnecessarily postponing decisions or by pretending to ignore problems in hopes that they will go away. For most people, these temporary escapes do not lead to great difficulty. For others, a tragic pattern is set in motion that becomes more crystalized as stresses mount. The end result may be flight into a world of total fantasy.

In some fashion we all have to keep dealing with reality with whatever assets we have. We all have different abilities, different opportunities, and differing levels of intelligence. We have little control over having or not having certain assets. However, we can control the way in which we use whatever tools we do have and, together with a full acknowledgement of reality, can develop a pattern of behaving and relating in the most effective way.

ADAPTABILITY. This is perhaps the most crucial ingredient in emotional maturity and, subsequently, especially essential in relating in a healthy, satisfying manner. The most striking difference between emotionally healthy and unhealthy persons is their degree of flexibility.

The healthy person has the ability to easily adapt and accept a wide range of people and situations. By contrast, the unhealthy person is rigid, judgmental, defensive, and rejecting.

Adaptation in this framework does not necessarily imply agreement with the person or situation nor a reluctance to express one's own ideas. However, it does imply the necessary flexibility to relate to a particular person or situation in the most productive way.

Adaptability is based on a number of personality assets, all of which must occur through personal growth. These include self-confidence, comfort with one's own value system, and the inner security that makes acceptance of differences easy. Perhaps the most important ingredient in the ability to adapt is the establishment of an *observing ego*. Simply stated, this means the ability to observe oneself in a constructive, somewhat objective way.

It is important to identify differences between the person who is able to make adaptive changes in behavior versus one who approaches all situations in essentially the same way. Adaptive persons have an internal processing center that continually takes in data from daily experiences.

These data include self-observations, reactions of others to oneself, verbal and non-verbal cues, what one reads and hears, and what one senses by way of smell, touch and taste. Subsequently, data are examined, considered, retained, or rejected by the processor. From this process comes the basis for continual adaptive behavior that, in turn, equips the person to behave in the most productive way at all times.

In contrast, the person who is maladaptive and behaves in counterproductive ways has a faulty processor that is unable to receive and evaluate data. Consequently, there is no opportunity to tailor one's behavior to best meet a particular situation.

Faulty processors may stem from insecurity and defensiveness so that no data are internalized. Failure at processing can also be due to an excessive preoccupation with oneself or due to any prolonged internal or external conflict that ties up psychic energy.

READINESS TO RESPOND. This involves an awareness of the unique individuality of each person, a concern that each person should grow and unfold in his or her own right, and a perception of the inner feelings of others. The emotional maturity necessary to respond to others involves giving up the childhood wish of wanting to exploit others for one's own satisfaction.

The development of a capacity to derive satisfaction from productivity and caring for others was described by Freud as *object interest*. Such interest can only be achieved once a person is able to get beyond his inner concerns and use energy for loving others. This level of mature love is closely associated with

the development of a healthy sexuality in the early developmental years.

People can be classified into three groups insofar as their responses to the emotional needs of others.

The first group comprises highly insensitive persons who show little or no response to the expressed or unexpressed needs of others. Individuals who are both sensitive and insensitive to other's needs compose the second group. Their sensitivity is reflected in their readiness to respond to the expressed needs of others. Their insensitivity is reflected in the absence of any response to unexpressed emotional needs. In the third group are those persons who are highly sensitive in that they readily respond to both the expressed and unexpressed needs of those around them. Most people fall into the second category.

People in the third group are able to attain the highest level of interacting because of their willingness to put forth the time and effort to engage in non-verbal communication. Their ability to interact at this level is also due to an assumption that certain basic emotional needs are present in everyone. Some of them had childhood conditioning that sensitized them to non-verbal cues, while others became sensitized after reaching adulthood—usually through pychotherapy, sensitivity training, or other similar growth-promoting experiences.

CAPACITY TO BALANCE. The immature person is continually looking at situations from the standpoint of *what's in it for me*. The mature person, on the other hand, looks at situations in terms of what he can contribute. There are many forms of emotional giving; all take time and energy.

Non-judgmental listening, for example, is an important form of giving at this level. Taking the interest, time and effort to affirm another human being is another form of emotional giving at this level of maturity. Finally, giving oneself to others is the ultimate way of finding oneself and, consequently, enjoying life to the fullest.

Giving consistently to others at the emotional level mainly depends on a comfort with oneself and the absence of a fear of being exploited. It is impossible to give to others and not be taken advantage of at times. A person who cannot tolerate this is necessarily always on guard and, consequently, unable to fully give of himself. All close, healthy relationships involve some degree of hurt, rejection, and unconscious exploitation. Emotional maturity depends on developing a tolerance for the frustration inherent in such interaction.

EMPATHIC UNDERSTANDING. Empathy can be defined as the ability to put oneself in the shoes of another person and sense how they feel or think. For example, it is not enough to merely know that another person is angry. Instead, one must know that underneath that anger are feelings of hurt, fear, sadness, or loneliness. Empathy can only be developed once the individual has grown beyond a preoccupation with self and self-fulfillment.

Children and adults can often be helped to develop this capacity through role play. Switching roles forces one outside one's own skin and into the skin of another. Another way to help children develop this level of maturity is to occasionally ask them how they think the other person felt after a particular interactional experience.

CHALLENGING ANGER. The first thing to recognize in successfully managing anger is that it is a natural emotion. Secondly, it is important to realize that anger is a gross emotion and is always a cover up for more subtle feelings such as hurt, rejection, sadness, and loneliness. An acceptance of one's anger, plus getting in touch with the underlying feelings, can go a long way toward successfully handling anger by channeling it into constructive outlets.

The most important factor in handling anger in an emotionally mature manner is a determination of one's vulnerability to external stress. Everyone has a buffer zone between the inner self and the external world.

For some, the buffer is too thin and, consequently, it renders them overly sensitive to external stimuli. This high degree of sensitivity comes about because the buffer zone allows too much of the world to come through to the inner self without adequately filtering out material that is too painful to the self. Other people have a buffer that is too thick, which renders them insensitive to others, since too little stimulation comes through to the inner self.

A workable, mature buffer zone is based on the development of feelings of security, self-worth, and a relative absence of competitiveness. The effectiveness of this zone can be greatly increased by sensitizing or desensitizing persons to external stimuli through reconditioning experiences.

These foregoing characteristics of emotional maturity are by no means all-inclusive. But they do spell out the most important ingredients of developing a healthy capacity to relate to others. Behavior at this level allows the person to not only relate at an adult level by having command of himself, but permits him to enjoy it as well.

Only a small percentage of adults in our society ever achieve the level of relating I've just outlined. Many have the capacity to do so, but they never are given the necessary help —either through mental health education, counseling, or psychotherapy. Many others do not have the capacity because of damaged self images through physical handicaps or because of having experienced sufficient emotional trauma early in life so as to render them emotional cripples.

All caretaking forces in our society should continue to conceptualize their experiences in helping others. Only in that way can we advance the efforts to prevent and correct emotional disorders and, in so doing, further man's quest for inner peace. ■

THE impact of unrestricted human population growth upon our fragile biosphere has concerned scientists for much of this century. Concern with the psychosocial and humane consequences of family size and birth planning has been less visible. Until very recently it has not been a major factor in the decisions of health and social policymakers.

Mental health professionals are, themselves, tardy newcomers to the scene. Long occupied with man's psychosexual life they have not, with few exceptions, devoted significant attention to fertility-related behavior as such, the factors influencing it, and its consequences for individual development and family life.

With that in mind, let's examine some facts and ideas about human reproduction that may be useful to mental health policymakers.

To begin with, procreation is one of those aspects of life associated with individual autonomy that tends to be regarded as a *right* rather than a *privilege*. However, when it conflicts with other codes or values, those with the greatest institutional strength tend to prevail.

What comes into play here is *institutionalized behavior*—an expression used by Talcott Parsons to designate the conformity of a significant segment of the community to certain values. This behavior, in turn, may influence fertility in accordance with beliefs and values about ideal family size, women's careers alternative to motherhood, children as an expression of masculine virility, expectation of economic support in old age, and the like.

Values, with their associated beliefs, attitudes, myths and practices, are all part of the socially inherited design for living called *culture*. Behavior, which receives immediate and long-term rewards on both a cultural and individual basis, is powerfully resistant to change. In the case of fertility-regulating behavior, it provides a unique meeting ground for the influence of personality and culture.

Many investigators have suggested that the effectiveness of a person's fertility control is related to the acceptance of his or her sexuality. For example, women who are ambivalent about sex and unable to assert themselves without hostility in a heterosexual relationship seem least able to regulate their fertility. Similarly, the most self-absorbed and sexually hostile men take little or no responsibility for conception.

In traditional societies a series of studies have emphasized the husband's role. Men have been angry at losing their freedom to produce children without responsibility as a concrete expression of power. Women have concealed the use of contraceptives from mates fearing their anger at this expression of a wish for greater freedom. Even in rural parts of socialized countries, women have not used contraception because of their husbands' concern about its possible effects on their sexual vigor and the persistent feeling that production of sons enhanced their masculine status.

Biomedical research already permits man to manipulate his own destiny in a manner previously reserved for nature. This is true for his destiny as a species as well as an individual. Such power, still largely unconfronted, requires a deliberate focus by policymakers on behavior formerly determined by the interaction of individual psychodynamics with custom and habit.

Dr. Brody is Professor and Chairman, Department of Psychiatry; and Director, Institute of Psychiatry and Human Behavior, University of Maryland School of Medicine, Baltimore. He is also Chairman of the APA Task Force on Family Planning.

ADVANCING technology stimulates development of new social inventions and institutions and reemphasizes—sometimes in maladaptive ways—traditional values and symbolic forms. These may contribute to the failure to use or abuse new techniques. The control of human fertility is a prime case in point.

Neglect, ineffective use, or active resistance to contraception and to the family planning philosophy have begun to concern health and social policymakers, especially in countries whose birthrates preclude their providing minimal living standards for their populations. At the same time, there has occurred new public recognition in the modern industrial nations that their freedom *not* to conceive has been effectively curtailed.

In the United States, for example, tax laws have penalized childlessness and bachelorhood. The use as well as the sale of contraceptives has been prohibited in some localities until the very recent past. The legal right of women to interrupt their unwanted pregnancies at will is still not totally assured. The cultural incongruity of many legal statutes still being tested in the courts — such as Massachusetts' *Crimes against Chastity* — is just beginning to attract public attention.

Today's developing resistance to these legal restrictions accompanies a reduction in the guilt and anxiety that previously encouraged automatic conformity to laws fitting neither the rest of the judicial code nor United States' psychocultural realities. These changes are part of the continuing evolution of public morality—a complex development including changes in attitudes toward women's rights, pre- and extra-marital sex, commercial pornography, and homosexuality.

Even in the developing countries and within minority groups in our own, the new concern with the quality of life has not allowed population policymakers to be conflict-free. The theme that one man's birth-control is another man's genocide has been heard in many ways throughout the world.

One attitude was epitomized by a statement from a local NAACP official in 1969: *(Black) women need to produce more babies, not less . . . until we comprise 30 to 35 percent of the population, we won't be able to really affect the power structure in this country.*

Similar political factors influence population policymaking elsewhere. Some listed in a recent Ford Foundation report include: the belief that international power requires a larger population mass; the wish for more military manpower; the greater short-term political appeal for insecure leaders of immediate economic and health priorities than of long-term development projects such as family planning; and, as in the United States, ethnic-racial awareness.

Policy approaches to fertility-regulation have, in general, been of two varieties. One has considered the use of deliberately imposed behavioral controls, including both the application of restraints and the offering of incentives. These range from massive economic rewards and penalties to licenses to reproduce, tax incentives for small families, and rewards to an entire group or community for family-limitation performance, e.g., if a certain proportion of males receive vasectomies.

The other approach has been in terms of deliberate efforts to induce culture change, i.e., to modify the values, standards, and symbolic forms of the society in a manner that will reinforce the self-regulation of fertility and reduce family size. Changes in the legal-judicial code, simultaneously reflecting and further modifying social values, fall

somewhere between induced cultural change and the use of deliberate controls.

Cultural change is already occurring as a consequence of new contraceptive technology, its increasing availability, and deliberate attempts at mass education. Much of this education has dealt with information about available contraceptives. It has also included a range of factors from the *abstract*, e.g., the impact on job opportunities of increasing population density, to the *personal*, e.g., encouraging women to predict the impact of having a child on their own as well as the child's future.

Culturally based obstacles to contraceptive usage may also be located in the gatekeepers—those who dispense family planning values as well as materials, knowledge, and skills to the consuming public. Other human variables in the chain of contraceptive behaviors need scrutiny.

MY work in Jamaica has highlighted lack of comunication between couples as a key factor in their failure to use contraception. This was related both to childbearing practices discouraging communication about sex between Jamaican children and parents to the institutionalized aspects of relationships between men and women on the island.

On the basis of these findings I recommended, at a meeting of the Jamaican Mental Health Association in Kingston in March 1972, that strong support be given to family life education in the schools and, if possible, to groups including daughters and mothers.

These details illustrate the broad policy front along which culture change may be reinforced in a particular direction. Direct mass education about contraception aimed at sexually mature individuals is only one approach, and possibly the least effective.

Early programming in family and school, opportunities for men to affirm their masculinity in ways other than sexual, encouragement of new patterns of communication between the sexes, the opening of respected careers alternative to motherhood, systematic attitude change among public health bureaucrats and professionals, modified sales techniques for sensitive items, all require for their implementation deliberate decisions by policymakers.

The same is true for the development of social laws requiring that every parent be held accountable for every child he or she brings or causes to be brought into the world so that it has the maximum opportunity to develop into a fully competent adult.

Policy requires agreement among independent persons who have often attained decision-making power through considerable efforts of their own. It may be determined not only by their own convictions, but by their wish to remain in power. This involves their perceptions of what their peers as well as the electorate want or will tolerate.

In the case of directing boards, such as that of NAMH, the question may revolve around what the membership or local associations want. Failure to act decisively by political leaders or by those of citizen's organizations with lobbying power often reflects an overestimation of the resistance of the electorate or the membership to social change.

A decision impinging on such traditional values as the freedom to reproduce will be based on the prediction of sufficient acceptance not to cause political damage. It may also reflect sensitivity to other institutions, such as the church or competing lobbying groups, whose goodwill is often useful. Thus, policy recommendations concerning fertility-related behavior may be obscured by presentation as part of a program supporting already accepted cultural values, e.g., an improved public health program.

In June 1971, a joint resolution in favor of zero population growth was introduced into the United States Senate. Couched in the language of traditional American ideals, it urged stabilizing the population by voluntary means *consistent with human rights and individual conscience*. Nonetheless, it marked a major departure from many of this country's traditional values, ranging from the religious one of not interferring with God's will to the economic one of unending growth, whether of people or GPN.

In February 1973, the Supreme Court announced its historic decision placing responsibility for abortion in the early months of pregnancy in the hands of the potential mother herself, albeit in consultation with her physician.

Such actions grant authoritative permission *not* to affirm one's personal integrity or sociocultural identity by reproducing. They also grant permission to engage in traditionally tabooed, guilt- and shame-ridden activities. Thus, they go far in transforming the value systems of those whose comfort depends upon their winning the approval of parent surrogates.

ADOPTION by a country such as the United States of an explicit population policy for itself may ally the fears of smaller nations and encourage them to do likewise.

These combined legal-ethical decisions—milestones marking the evolution of our culture—indicate the direction of societal change as well. They underscore the need for a definitive Federal science policy and a clear definition of Federal responsibility for the public health.

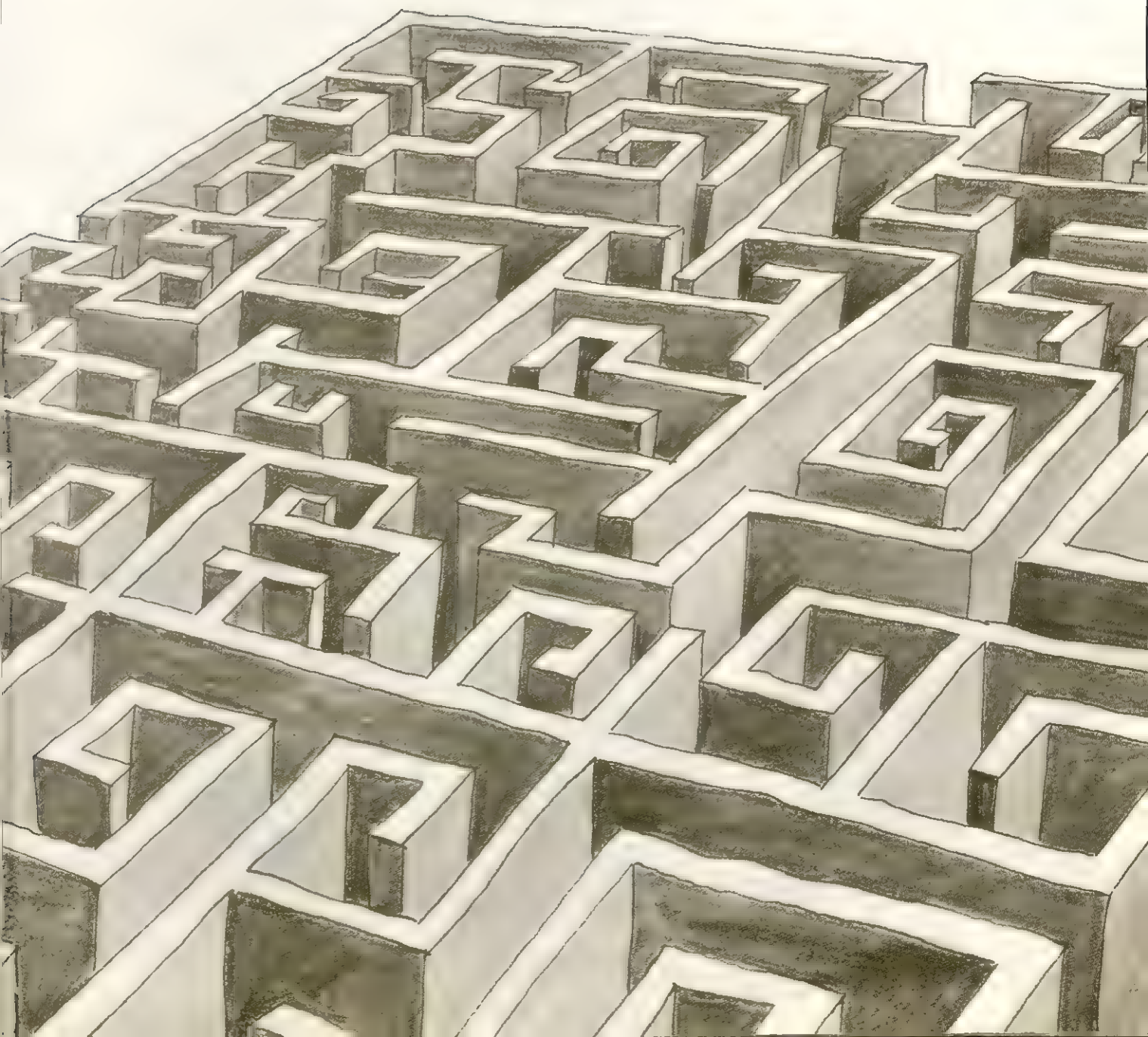
A public policy concerning fertility-related behavior would significantly touch every other aspect of the social control system, especially in regard to health, education, and welfare-related behavior. Explicit governmental policy on an issue so close to what individuals still regard as an inviolable area of self-determination would be experienced by many as frightening. Its potential ramifications for mental health are immense and so far unexplored.

The systematic examination of this issue by mental health leaders may illuminate the whole issue of social control by currently unidentified custom and public policy, and permit a more realistic basis for projecting the future. ■

A bright, new NAMH film
called *JOURNEY*
evokes a kaleidoscope of

IMAGES

By Bill Perry Jr.



IMAGES

Ours is now a visual age.
Conscience, for good or evil, is shaped much by a single medium.
Pictures of real war and silly situation comedies are curiously juxtaposed and channeled simultaneously.

Much of our Journey through life is a vicarious adventure, cast on a white rectangle in darkened rooms.

Man dreams, and the dreams leap into being in technicolor images with knob controlled sound.

What is this Journey, this approximation of who we really are?
Can that be us, those images acting out our situation?

Are those our surrogates? Or is that our life seen in controlled reality?

Take a look at the mind of man, add Imagination, edit here and there, listen to the sound of the Road, and we are indeed captured

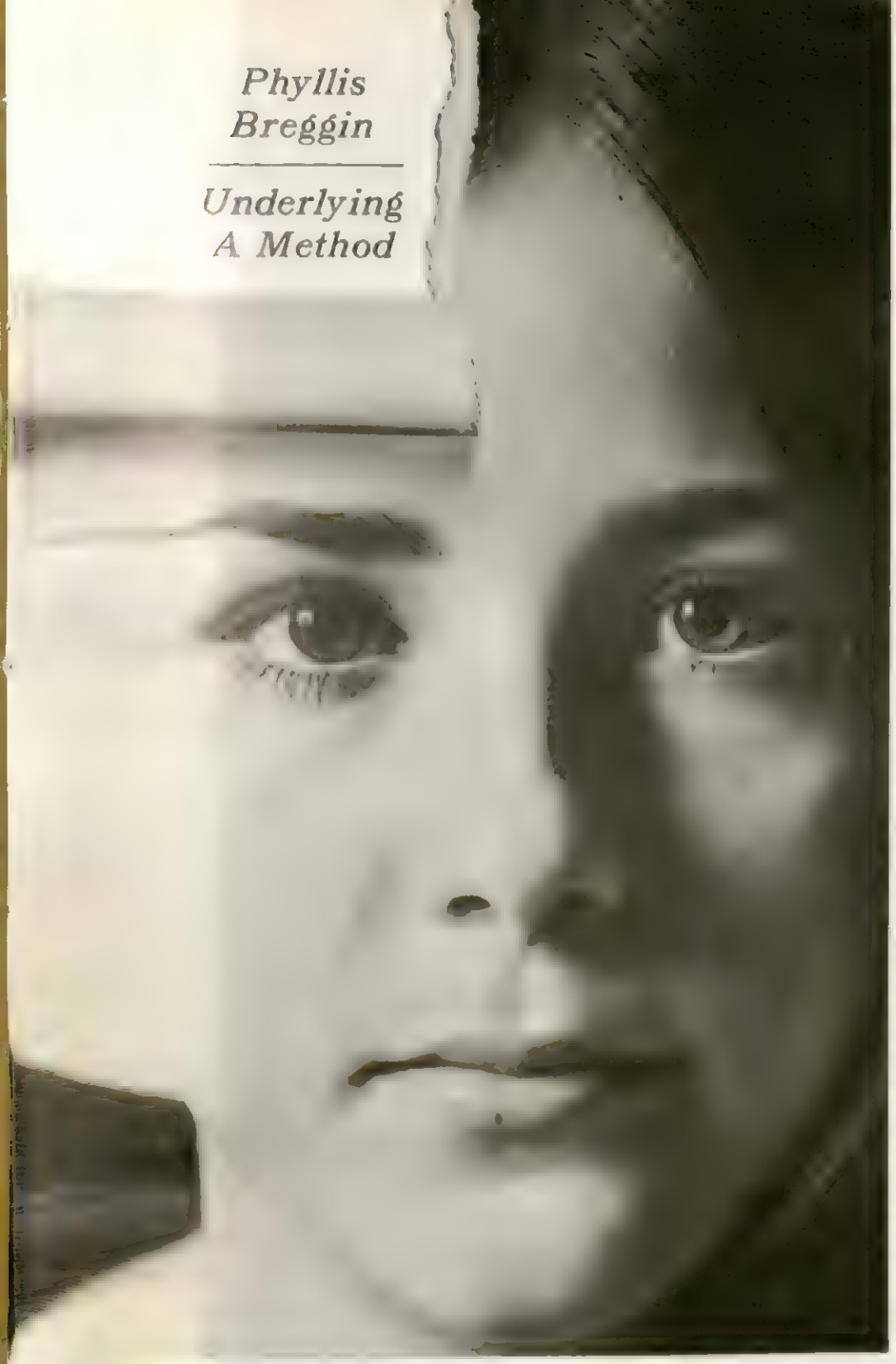
Frame by frame we travel, safely the film lets us watch ourselves perform as we move ever on through the Journey we all must make.

Where does our Journey lead?
Where, where indeed?
To help, for those in need.

B.P.

IMAGES

**JOURNEY — to help,
for those in need.**



Phyllis Breggin

Underlying A Method

Is psychosurgery an acceptable treatment for "hyperactivity" in children?

HYPERACTIVITY in children has become an issue of great concern among parents, educators, doctors, and even the Federal government. In the face of much controversy and contradictory evidence, a government-appointed panel recently declared amphetamines to be a *safe and proper treatment for children suffering from a behavioral disorder*. Hyperactive children in the United States are currently being treated experimentally not only with drugs, but with psychosurgery—an operation that destroys brain tissue for the control of behavior.

Although both Congress, The National Institute of Mental Health, and the Justice Department have financed some of the psychosurgery on adults, as of yet, no government panels have declared psychosurgery *safe and proper*. In fact, efforts led by the Project to Examine Psychiatric Technology have brought a halt to all Federal funding for psychosurgery and encouraged several senators to sponsor a bill placing an official moratorium on this spending. Now is the time to examine the facts about psychosurgery as a *treatment* for behavior some people classify as undesirable in children.

Phyllis Breggin is Research Director for the Project to Examine Psychiatric Technology at the Washington School of Psychiatry, Washington D.C.

Editor's Note: Several professionals requested to have opposing views from that of the authors were invited by MH to respond to this issue of psychosurgery but they declined to do so.

A 9-YEAR-OLD of average intelligence, J.M. is described as *hyperactive, combative, explosive, destructure, and sadistic.* In 1962, for the purpose of management and control, he was given the first of a series of six mutilative operations on portions of the emotion-regulating centers of his brain.

After this operation J.M.'s behavior *improved,* enabling him to return to special education. A year later, *symptoms of hyperirritability, aggressiveness, negativism, and combativeness slowly reappeared.* He was returned for coagulation of the fornix, a structure associated, among other things, with memory. This operation resulted in a worsened condition; that is, his behavior moved toward more activity rather than more docility. He also suffered brain damage.

J.M. is one of the relatively few children in the United States recently subjected to mutilating operations for behavioral disorders. Only a handful of the many psychosurgeons who are currently operating here are performing these operations on children and adolescents. However, many indicators point to an imminent increase in this type of procedure for children, especially those described as *hyperactive.*

Psychosurgery on children is already being done on a large scale around the world. Balasubramanium, an Indian neurosurgeon well-known among Western psychosurgeons, calls his operations on the amygdala, an almond-shaped location in the temporal lobe, *sedative neurosurgery.*

He states, "Once the intensity of the behavior disturbances is severe enough, surgery is warranted, and should not be denied merely because the patient is young." Behavior disturbances that he feels warrant surgery include *wandering tendency* and *restlessness.*

Chitanondh in Thailand and Narabayashi of Japan have been performing amygdalotomies on children by electrocoagulation. Narabayashi and Uno report that 27 children—ages 5 to 13—who have had this surgery are *characterized by unsteadiness, hyperactive behavior disorders and poor concentration, rather than violent behavior; it was difficult to keep them interested in one object or a certain situation.*

Sano, a Japanese psychosurgeon, recently toured the United States speaking about his operations on children. In 1972, he published a report on hypothalamotomy on 79 patients, 26 under the age of 15, who are characterized as *violent, aggressive, restless.* His aim is to *calm down or correct patients with those behaviors.*

Psychosurgery on children is not a new phenomenon in American psychiatry. Freeman and Watts in the Forties and Fifties performed approximately 4,000 frontal lobotomies, including some on children.

Reporting on a dozen children, ages 4 to 14, they conclude that their results are unsatisfactory in some ways, since none of these children ever returned to normal home living, but satisfactory in others, since they were less aggressive in the hospital after the operation.

Freeman is no longer with us, but a number of other psychosurgeons here have picked up the leucotome or electrodes in his place. An estimated 400 to 600 operations are performed here each year.*

O. J. Andy, director of neurosurgery at the University of Mississippi School of Medicine, published a 1972 study of 30 thalamotomy patients, half of them under 20 and more than a third under 12. Andy's goal is frankly stated in a letter to us by his associate, Jurko: *reduce the hyperactivity to levels manageable by parents.* Petter Lindstrom, using ultrasonic radiation, has operated on the frontal lobes of 475 patients in the last 16 years, the youngest being ages 11 and 13. H. T. Ballantine's group at Massachusetts General Hospital has performed cingulotomies on a wide variety to individuals, the youngest in their published article, age 15. Both men claim that few of their patients are children.

The press and the Project to Examine Psychiatric Technology have uncovered many psychosurgeons who were operating and not publishing the results. Just as the number of doctors who prescribe amphetamines for hyperactive children is unknown, so the psychosurgeons may go about their operations unrestrained by review boards or even a central reporting system for the numbers and types of operations performed.

THE psychosurgeon's goal is permanent behavior modification directed at management, control, and conformity. They have stated their interest in operating on children who require extra effort and time on the part of parents, teachers, or hospital attendants. They wish to control these children so that they will never require extra care and attention again.

In the *successful* cases, where the surgeons do accomplish a great degree of management and control, they do so by blunting the child's emotions, dampening his energetic desires, and so quieting him down.** Their successes are not children who are more independent, more aware of and able to relate to the environment, or more creatively capable of dealing with it, but rather are increasingly dependent upon the family and society, but in more socially acceptable ways. They are less trouble because less of their spirit remains to be troublesome.

Aside from the validity of the goal the psychosurgeons (and the parents, teachers, and attendants) have in mind, the method itself is in no way justifiable. In order to accomplish management, many other aspects of the personality must be sacrificed with the loss of brain tissue. The frontal lobes and the limbic system are well integrated

* For a more detailed account, see *The Second Wave* by Dr. Peter R. Breggin in the Winter, 1973, issue of *MH.*

** In O. J. Andy's study, only three out of the 30 children are listed as *good* results, the highest category; the rest of them are in the *fair* and *poor* categories.

with many interconnections throughout. There is no *violence center* or *hyperactivity center* in the brain.

The amygdala, thalamus, hypothalamus, and other emotion-regulating areas of the brain perform many integrated functions. Removing any of these structures will blunt such aspects of the personality as creativity and learning, in addition to blunting violence, aggression, motion, or restlessness.

Although the blunting effects of psychosurgery have been well documented both in animal and human experimentation, the actual procedure is still highly experimental. And no controlled psychosurgical studies have ever been done.

There is also little evidence that the problems of hyperactive children are generally neurologic or biologic in origin. As Lloyd J. Thompson writes in the April, 1973, issue of *The American Journal of Psychiatry:*

> *In diagnosing brain damage, we consider the medical history, the neurological examination, the psychological studies, the EEG and X-ray findings, and clinical observations. It is contended, however, that positive findings in any of these fields may be due to developmental lags* (rather than from brain damage).

Moreover, hyperactivity in children is widely known to be a self-limiting phenomena. On this point, R. L. Jenkins states:

> *The hyperkinetic or hyperreactive reaction is widely recognized in child psychiatry. It is disproportionately frequent before the age of 8 and tends gradually to become less frequent and less prominent thereafter. It usually disappears by the middle teens. . . . There is no present justification for assuming that all cases are due to organic brain damage.*

Psychosurgery is an irreversible process; damaged brain cells deteriorate rather than regenerate. A victim of such an operation can never recover the loss of a portion of his brain and his related capacities to create, to learn, to choose, in essence, to be a free person. Certain choices and responses have been irrevocably taken away from him.

The purpose of management through psychosurgery is obviously not one of making the child more able to learn or create. Nor is it aimed at rooting out the cause of the child's enormous difficulty in dealing with the world around him. Psychosurgery, through eliminating part of the personality, instead makes searching for the meaning behind behavior close to impossible. Above all, the goal of control is not pursued for the benefit of the child. A child cannot give informed consent, and most often, the person who consents *for* the child is the very person with whom he is in conflict.

COMPARED to adults, young children are usually *hyperresponsive* to various stimuli. This may increase when the child is restrained or punished. It does not become a *disease* entity until someone (parent, institution) wishes to control the child in a way that is not in his interest, but in the interest of the parent or institution.

John Holt, who has been waging a campaign against the drugging of children, takes this viewpoint:

> *Children have a great deal of energy; they like to move about; they live and learn with their muscles and bodies, not just their eyes and ears. When adults try to compel them to remain still and silent for long periods of time, they resent and resist it. Most of them can be cowed and silenced by various bribes and threats; 5 to 15 percent cannot. These we diagnose as suffering from a learning malady called* hyperkinesis. *. . . We consider it a disease, because it makes it difficult to run our schools as we do . . . for the comfort and convenience of the teachers and administrators who work in them. The energy of children is* bad, *because it is a nuisance to the exhausted and overburdened adults who do not want to know how to and are not able to put up with it.*

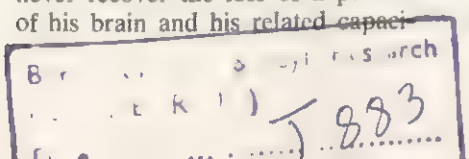
Most of the children who are operated upon do have severe problems, although it cannot be said that a 5-year-old is a *last resort* case. Some of them are too young or too distraught to even be psychologically tested. Many are institutionalized, and some are diagnosed as mentally retarded. Still, this is no excuse for launching a physical assault on them.

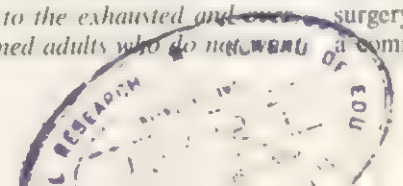
No matter how difficult a situation or what its cause, when dealing with children one must not succumb to the easy solution of getting them out of the way as cheaply and efficiently as possible. By taking a child who is full of feelings and making *an example of model behavior in a mental hospital*, one merely sacrifices the child and absolves the parent or institution of any responsibility it may have had in creating the child's problems.

William Scoville, president of the International Association for Psychiatric Surgery, has commented on the *gentling* effect of amygdalotomies. If a gentle child is the desired effect, one way to achieve it would be to make the child's surroundings, his parents, and his keepers more gentle.

Anyone who has heard of Willowbrook knows that the places mentally retarded children are forced to live in are not gentle. Nor is the children's division of the state hospital from which some of these young patients come. Inner city ghettos whose schools have the most problems with hyperactivity are not gentle; indeed, most families are not gentle places. Considering this, it is a wonder that more children do not exhibit *aggression, emotional instability,* and *social maladjustment.*

Parents are asked today to put their hyperactive child on drugs. If the trend toward psychosurgery continues to grow, they may soon be asked in greater numbers to alter their child's behavior permanently by removing parts of his brain. There is still time to keep psychosurgery on children from becoming a commonplace occurrence. ■





Psychosurgery: An NAMH Position Statement

UNTIL there has been more research concerning the cause of the various manifestations of mental and emotional disorder and until there has been more research through the use of non-human subjects related to the functioning of the brain:

- Psychosurgery should not be used except in those instances where the patient is in such great personal distress due to his mental disorder that he, by his own choice, would prefer such psychosurgery rather than to remain with his existing condition, and where all other alternatives have been considered or have been given an adequate trial as defined by consensus of the patient, his family, and at least two reputable physicians, one of whom should be a psychiatrist.
- The procedure to be followed has been reviewed and has received the written approval of at least two other neurosurgeons not associated in practice with the surgeon selected to perform the surgery.
- The patient has legal representation present with him when any final decision is to be made regarding the operation, in order to make certain that the patient fully understands the possible consequences of his decision and in order to be sure that the patient knows that he is free to refuse such treatment prior to its accomplishment, even if he may have previously agreed to it.

This position, designed to serve as a guide in responding to inquiries directed to the Mental Health Association, was adopted with the following as background:

During the Twentieth Century, there has been substantial progress in the field of neurological surgery. Much of this progress has been in the area of understanding brain and behavior mechanisms. Simultaneously, safeguard techniques have improved and methodology in experimental therapeutics have been refined. The range of situations for successful neurological intervention of a treatment type has been greatly improved.

However, the recent reemergence of psychosurgery as a method of behavioral modification used in the treatment of some forms of mental and emotional disorder, as well as in neurological disease, has created public concern which will inevitably be reflected in inquiries directed to the Mental Health Association.

Some of those who will inquire about psychosurgery will be deeply concerned people engaged in a serious search for some ray of hope in the treatment of a disturbed member of the family who has failed to respond to any other presently known method of treatment. Other calls will come from those who are seriously and properly concerned about the possibility that psychosurgery will be practiced unethically and experimentally upon hospitalized patients, members of minority groups and others unable to protect themselves, or that it may not be used as a treatment procedure to correct a specific disorder but as a means to alter or control the behavior of those persons who act aggressively in social struggles for the recognition of their rights.

Psychosurgery, as contrasted with the broad field of neurological surgery, is a term best used to define surgical procedures on the structurally intact brain, not to correct or eradicate known or definite organic pathology, but by present techniques, to produce behavioral change. Introduced nearly 35 years ago by the Nobel Prize-winning neurosurgeon, Egas Moniz, one of the procedures, leukotomy or lobotomy of the prefrontal lobe or lobes, was widely employed during the 1940s and 1950s in the treatment of mental illness.

With the collection of data from large series of cases during the 1950s showing the limitations and risks, as well as the results of lobotomy procedures, and the simultaneous development of psychopharmacology

during the 1950s and 1960s, there was a reduction in the usage of psychosurgery in the United States.

In the past 5 years, however, there has been some increase in the use of newer procedures and renewal of procedures previously utilized, especially for those persons with complications resulting from long-term phenothiazene drug treatment. These recently recognized and undesirable consequences of drug treatment, plus the failures experienced in the use of other currently available treatment modes, add up to a sizable number of severely disturbed patients for whom new methods of treatment must be actively sought wherever there may be any promise or hope.

Particularly in the last 2 years, there has been a growing public concern about the apparent renewed use of techniques, which were formerly used to alter human behavior and which seemingly had been rejected. Certainly, it is appropriate that the Mental Health Association should react with grave concern about the dangers of indiscriminate psychosurgery and about the use of human subjects experimentally when the possible consequences are so serious, irreversible, and irremediable.

We must learn from recollection of the work of the Fifties, and from new concerns, especially with the ethical issues regarding informed consent of human patients, and we must proceed with a new sensitivity to potential abuses of medical, surgical and psychiatric procedures, particularly in relation to members of minority groups, prisoners, and the socio-economically deprived, as well as persons not competent to judge their conditions.

The following are underlying premises for the position adopted:

• Any use of psychosurgery must still be classified as experimental, even though in some instances it has proved beneficial to the patient involved, because so little is yet known about the causes of mental disorders and specific functioning of the brain. We are, in fact, operating in an area in which we do not have a known etiology.

• There is no consensus within the field of psychiatry or any of the professions directly connected with the treatment of the mentally ill concerning the effectiveness of psychosurgery as a means of treating mental disorder. We have only empiric evidence.

• Those who favor or engage in the use of psychosurgery are a distinctly small segment of those involved in the treatment of mental disorder. Most, however, are conservative and responsible serious-minded neurosurgeons who only operate in response to multiple appeals from family members, as well as from patients, concerning the torture and impossible complications of living and upon findings objectively demonstrating disease of brain or severe disorder of behavior.

• Most of the professionals concerned with treating the mentally ill take a very cautious attitude regarding the use of psychosurgery and would *not* consider its use, except possibly in rare instances where the patient, when able, regarded his condition as unbearable, and when there was no other alternative treatment, and when there was ample evidence that the surgical procedure to be followed might produce a desirable change toward improvement of behavior and personal rehabilitation.

• Psychosurgery is a procedure of such serious consequences that it gives rise to ethical issues related to the capacity of the patient to give consent, particularly if that patient is involuntarily confined, or for other reasons can be assumed to feel impotent in the face of legal, fiscal or medical authority.

Adopted by the Board of Directors on June 5, 1973.

By Donald J. Dawidoff, L.L.B.

IN the practice of psychiatry, there are numerous legal risks that may be encountered. Not all of them may be effectively guarded against in day-to-day office practice. Here are several of the more common risks and some suggestions for avoiding or mitigating them.

CIVIL MALPRACTICE. The most frequent source of legal difficulty for the psychiatrist is the civil malpractice claim—a potent weapon for the aggrieved or paranoid patient.

Here, the legal threat to the psychiatrist is physical injury. More difficult to establish, however, is non-physical negligent abuse . . . where the body bears no bruises or fractures. Only with the various remedies for wrongful hospitalization have patients consistently achieved some success.

Protection against possible claims in this area may best be accomplished by keeping detailed records. These should include not only symptoms and treatment, but also citation to relevant literature and all matters bearing on the consent obtained from the patient.

Moreover, note should be made of his cognitive ability, perceptive capacities, and disorders. For it may be necessary in the case of a patient with severe perceptual incapacity to obtain the consent of a parent, guardian, or spouse.

Recording the treatment rendered, making memoranda of the cooperation from family, and describing the outcome of consultation may all prove helpful in a case of civil malpractice.

DRUG THERAPY. Of more specialized but continuing efficacy are the precautions to be taken when drugs are prescribed. With the use of the more frequently prescribed ones, such as the Phenothiazine preparation, various extra pyramidal complications may occur and trigger malpractice litigation.

Similarly, there are package inserts that accompany drug samples given to psychiatrists by drug companies. When a psychiatrist does not closely follow the precautions laid down in this literature, the door to malpractice litigation may be open.

Likewise, it is important that the patient be kept on his drug regimen. Without endangering his trust in the physician and in himself, it may be helpful to enlist the aid of a family member or roommate to assure that these drugs are taken in their regular and proper dosage, and that with the depressed patient, for example, no pills are hoarded.

One must try to assure himself in such instances that more than one

Mr. Dawidoff is a member of the New York and District of Columbia bars and practices law in New York City.

physician is *not* being consulted at the same time for the purpose of building up a supply of drugs that are harmful in large dosages. In this regard, direct questions to the patient may not always prove fruitless.

COMMITMENT. The psychiatrist may find himself in a quasi-public role in managing the potentially suicidal patient. Many psychiatrists might argue that the physician is capable of perceiving the extent of reality distortion by his patient. But in signing commitment papers, some duty of independent investigation or questioning third parties may be thrust upon the physician.

UNDUE INFLUENCE AND TRANSFERENCE. As Freud declared, the psychiatrist must not take advantage of transference idolatry to mould the patient in his own image. The psychiatrist is always a fiduciary, and must not orient his treatment for personal gain or be guided by other than the patient's medical interest.

Aside from the therapeutic reasons for avoiding overweaning dependency, there is a legal reason for keeping clear of undue influence and the acceptance of special benefit.

In this light we might contrast two cases: In *Landau* v. *Werner*, a 1961 British case, a psychoanalyst was held professionally negligent for embarking upon a course of social visits with a female patient who, as a result of the transference, found herself *in love* with him.

The visits were adjudicated to have destroyed an otherwise successful transference cure. The court appears to have held the analyst liable, not because any personal advantage or bad faith was marked in the treatment, but because the social visits made separation impossible and confused the patient by introducing a potential relationship of lover and loved one.

In *Zipkin* v. *Freeman*, a Missouri Supreme Court decision in 1968, a patient gave her psychiatrist large sums of money, lived in an apartment above his home, and engaged in business ventures with him. Although the court did not so decide, the case suggests the misuse of the transference in the civil as well as the medical sense. Great care in managing the transference, especially where extra-office contact is embarked upon, is most advisable.

A further aspect of this is to be certain that suggestions are suggestions and prescriptions, prescriptions. When a psychiatrist tells a patient that a little sex would do him good or that he should stand up to his boss, the physician should be certain that the patient is capable of taking his advice as a suggestion rather than as medical direction.

Failure to do so may invite a lawsuit where the patient blindly follows advice to his own or a third party's detriment. This is especially the case with young people and patients whose marriages are in uncertain waters. When he does give advice, the psychiatrist would be wise to write a memorandum of his suggestion for his own records. Records made in the regular course of business are often strong defensive aids when litigation arises.

THE CRIMINAL LAW. The most serious, if infrequent, legal jeopardy in which a psychiatrist may place himself is criminal. At the outset, there are the criminal consequences of practicing medicine without a license or of committing sexual abuse on a patient. A psychiatrist might be found guilty of a crime for acts committed on his patient, even if performed in the sincere belief that such acts may be therapeutically beneficial.

Basic to all phases of psychiatric conduct is the need to guard against the filing of a criminal complaint or a malpractice action by an angry or, perhaps, paranoid patient. Such an individual may imagine things that the physician has done, such as invitations to intimate sexual behavior, caresses and, even, sexual assault.

Defenses against these thoughts or hallucinations may be asserted by documented and witnessed testimony to one's reputation, repeated lack of endorsement of such behavior, happy family life and, perhaps, though it may be discouraged on therapeutic grounds, the testimony of other patients.

In avoiding this as well as other forensic embarrassment, it may prove beneficial to keep extensive notes on encounters and sessions with patients, especially where palpable negative transference, active paranoia or like symptomatology is evident. It may also prove advisable in such instances to keep the door of the consultation room ajar or to have a nurse in the next room. Unfortunately, such precautions may be detrimental to the therapy itself and more particularly to maintaining the patient's trust in his physician.

Another area of extreme difficulty comes about, perhaps, because of some conflict between analytic amorality and the moral tenor of law. Classically, the analyst would take no active part in the patient's life in the sense of directing him toward or away from activities outside the therapy. However, any aspect of this outside life that may be criminal should be discouraged or the patient actively involved therein dropped from therapy.

All in all, good faith alone may not always protect the psychiatrist against hostile patients or retributive relatives. But when problems are encountered or suspected, legal advice may be good *preventive medicine.* ■

BOOKS

Beyond the Best Interests of the Child
Joseph Goldstein, Anna Freud, and Albert J. Solnit
New York: The Free Press, 1973. 161 pp., $7.95 (hardcover), $1.95 (paperback).

If a new book had no title and only the names of three authors on its cover—that would be enough to recommend it. On the other hand, if this particular new book had been written by some unknown, it would become a little classic—required reading for lawyers, psychiatrists, psychoanalysts, and all laymen interested in mental health.

Few of us have realized how tragically and how shockingly our laws ignore scientific knowledge of the development and vulnerabilities of children. This book not only makes us see, but it offers solutions and proposes new laws as well. Implemented, the new codes could prevent an enormous amount of human damage, damage now left to our all-too-scant pounds of cure.

The new laws would provide the child with his *own* advocate—one who could truly represent his interests. Instead of allowing procrastination about placements to drag on for months or years, each case would be treated as a matter of urgency to be settled in terms of days. The least detrimental alternative would be sought for the child, and it would be the child whose interests were paramount. At the same time these laws would safeguard the parents' rights to raise their children free of governmental intrusion, except in cases of neglect and abandonment.

Regretfully, a relatively minor point must be raised that seems to mar the book. The authors argue that children *will freely love more than one adult if the individuals in question feel positively to one another.* From this psychoanalytically debatable premise, the authors recommend that the divorced parent who has been awarded custody of the child have final and unmodifiable custody, and further that this could mean *total* control of visitation rights.

It seems incredible to me that a court could rapidly decide who should have such total and irrevocable custody. After all, parents may change, and children's needs may change. Also, after deciding who should have custody the courts could permit—really invite—a potentially distraught, angry, and vindictive parent to have the power to prevent contacts with the other parent. I have seen cases in which the maintenance of contacts between the child and his non-custodial parent, even over the objections of the other parent, have been psychologically life-saving.

Thus, in attempting to save the child the pains of split loyalty, the authors would increase the possibility of a total loss of one of the parents. What would *that* mean psychologically?

Children—however painfully—can, and often do, survive and live through loyalty conflicts. But the damage from a total loss of one of the parents is not always correctible; even a tenuous relationship with an ordinary non-custodial parent is better than none at all.

Nonetheless, the authors provide workable legal procedures that could utilize the best available knowledge for the sake of the child and his—and our—future. This is such an important book, one that can potentially have such beneficial social effects, it behooves all of us not only to study it, but to *act* upon it.

VANN SPRUIELL, M.D.
New Orleans, La.

The Joys and Sorrows of Parenthood
The Group for Advancement of Psychiatry
New York: Charles Scribner's Sons, 1973. 159 pp., $5.95.

This certainly ranks as one of *GAP*'s finest and most valuable contributions to the psychiatric literature. As such, it should be read by all in the field of mental health and merits frequent prescribing as bibliotherapy to many patients, clients, and friends. The style is refreshing with numerous delightful passages and a minimum of psychiatric jargon.

The book itself attempts to fill the hiatus regarding the dearth of writing about the needs, problems, joys,

and sorrows of parents. It emphasizes parenthood as a growing experience for parents and reminds them, among other things, that moral values are transmitted from children to parents, and that as a child need grow into adulthood, an individual cannot forever remain a parent. Parenthood is viewed as a stage in total life experience of an individual for which they prepare, but then benefitting from which, they can continue their personal growth to the next stage of their life cycles.

Parents who look only to their own experiences for guidance and understanding of their children's needs are bound to encounter frustration, bewilderment, and disappointment. Parents should maintain their autonomy, but also have the capacity to re-examine their own values and employ reasonable flexibility.

There are many fascinating chapters in this volume, including varieties of parent experiences—as an adoptive parent, a stepparent, a parent with a chronically disabled child. Also cited are emotionally upsetting circumstances through which one healthily may be able to grow. Grandparenthood is discussed, and the book concludes with a perceptive, but supportive, passage regarding being a parent.

GENE USDIN, M.D.
Clinical Professor of
Psychiatry
LSU School of Medicine
New Orleans, La.

Clinical Studies in Childhood Psychosis
S. A. Szurek, M.D. and I. N. Berlin, M.D.
New York, London: Brunner/Mazel, Inc.; Butterworths, 1973. 780 pp., $20.00.

Clinical Studies in Childhood Psychosis is a comprehensive collection of 33 papers detailing over 25 years of treatment and research by Dr. S. A. Szurek and his associates at the Children's Service of the Langley Porter Neuropsychiatric Institute.

It is organized into six sections including historical aspects of childhood psychosis, current clinical issues, clinical research, sexual problems with psychotic children in treatment, and therapeutic experience with psychotic children and their families.

Several topics are particularly well done and worthy of mention. The case accounts are honestly and convincingly presented, including a report of 10 years of psychotherapy with a schizophrenic boy and his parents. The discussions of attachment and psychotic detachment, the therapeutic milieu, the role of the child psychiatry trainee, countertransference difficulties, parental blame, and the psychodynamic approaches to childhood schizophrenia are exemplary of the pertinent papers included in this volume.

Throughout this work the compassion and empathy, the commitment to treatment, and the essential scientific objectivity come through. It is an invaluable text for anyone involved in the treatment of children, and especially instructive and encouraging to those who enter the therapeutic struggle with psychotic children and their families.

MARK BLOTCKY, M.D.
Department of Psychiatry
Southwestern Medical School
Dallas, Tex.

Children and Their Parents in Brief Therapy
Edited by Harvey H. Barten and Sybil S. Barten
New York: Behavioral Publications, 1973. 323 pp., $9.95.

The editors of this book, responding to what they feel is the need of making child therapeutic practice relevant to widespread community needs, have collected varied articles written over the past 20 years on brief therapy. In this, they have included a wide assortment of treatment aspects that might involve streamlining certain techniques such as drug use, behavior modification, crisis intervention, and brief psychotherapy with children, parents, families and groups. But approaches to special problems such as school phobia, early childhood disorder, and drug abuse have not been overlooked.

The child therapist using this collection may be able to expand his range of therapeutic techniques. But he

must be prepared to shift his orientation if previous practice has taught him to consider the child in terms of his functioning levels, his weaknesses and assets, and the total environmental field. He will, as it were, have to learn to focus immediately on the current problem. Likewise, if his training has taught him to consider the child as the primary patient, he may have to be prepared to scrap that idea, too, because brief therapy may involve his dealing only with the parents and, perhaps, doing mainly parent education. However, with an open mind and a desire to learn about time-limited, problem-solving techniques, this is a book to read.

As the editors state, the tempo and strategies of child treatment are changing, and there is a need to treat more people in the community in a shorter period of time with the limited availability of therapists. They feel that through the short-term therapy approach this challenge can be met. Whether we can assume that families can carry on the benefits that they derive from these techniques remains an important doubt to be considered.

ROBERT A. WIENS, M.D.
Associate Clinical Professor,
[illegible]

The Manipulator: A Psychoanalytic View

[illegible], M.D.

[illegible]
285 pp. $10.00

Using the phenomenology associated with the manipulator as a point of focus, Dr. Burston presents, in effect, a hard-nosed, western summary of current psychoanalytic theory and practice. The nature of the audience he had in mind is not clearly defined, but this reviewer feels the book might serve as an introduction to the field for a wide variety of workers in related fields as well as for the interested layman.

Very early in the text, Burston points out that the focus of interest to which he is addressing himself is the conscious aspects of the motivation for manipulative behavior. According to him, *the focus of the transactionalist* is primarily on external and currently active forces in the systems of which the individual is a part. They place less emphasis than does Dr. Burston and psychoanalysts in general on the importance of the genetic background and the stability of internal regulators of behavior.

For the purpose of this exposition, manipulative behavior is defined as having four characteristics: an initial conflict of goals, the conscious intention to manipulate, the presence of deception and insincerity, and the feeling of having put something over on [illegible].

The text can be characterized as an elaboration on the elements of this definition. For example, the emphasis on the role of conscious intentionality leads to an extended discussion of problems related to adaptation and psychic determinism. This, like each of the other elements in the definition, is elaborated with the assistance of clinical illustrative material. While these vignettes are not always convincing in the net they serve to underscore the author's points. Dr. Burston is to be congratulated for this very useful and instructive volume.

DAVID A. FREEDMAN, M.D.
[illegible]

A Selective Guide to Materials for Mental Health and Family Life Education

[illegible]

Northfield, Ill.: Perennial Education, Inc., 866 pp., $35 (paper)

The films and publications in the field of mental health make up a bewildering assortment. And their number is added to each month. It is hardly possible for the person who works in mental health to assess them all adequately.

In recent years the Mental Health Materials Center [illegible]

Selective Guide for Mental Health and Family Life Education. What makes this guide important is that every item is studied by a panel of experts, and those materials not chosen for [illegible] the ones finally selected.

Program developers will find that the items are recommended for certain groups, as for example parents of very young children, teenagers, retirees, etc. In fact, the whole Guide is by sections so that anyone looking for materials for a certain age group or in a certain problem area can, by consulting the index, turn at once to that section, which includes everything recommended by the Guide. There are also instructional sections on the better ways to use pamphlets and films.

Another important consideration in the Selective Guide is that it tells exactly where a publication or film may be had and at what cost. For the busy program designer, this is a great comfort.

Needless to say, this publication should be within arm's length of every person who purports to be a program director in mental health.

[illegible], Ph.D.
New Orleans, La.

The Relevance of Education
Jerome S. Bruner
New York: W. W. Norton & Co. Inc. 1971
175 pp. Paperback $[illegible]

In the midst of the numerous [illegible], [illegible] pressures, and other pressures [illegible] in the classroom, *The Relevance of Education* is a refreshing breeze that clears the [illegible] of basic thought.

Jerome S. Bruner has produced a small book of [illegible] and explains the effects exercised on them by powerful cultural conditions.

This book will appeal to classroom teachers, helping them to live with realistic goals even as they increase their understanding of and empathy toward the disadvantaged child. It will also be a revelation for both the average citizen and the lay school official.

[illegible]
Special Lecturer in Sociology
Louisiana State University
Baton Rouge, La.

Psychiatry: Education and Image
Edited By Gene Usdin, M.D.
New York: Brunner/Mazel Inc.
Butterworths 1973 180 pp. $[illegible]

This book (sponsored by The American College of [illegible]

It offers a stimulus to every psychiatrist for personal self-assessment and analysis of not only his current role in his chosen field but also of his capacity to change and move with the tide of scientific progress and movement of delivery of mental health services.

Among the nine psychiatric contributors, Robert L. [illegible] presents an appraisal of the current syndrome of criticism against psychiatry as an [illegible] of the major concepts of psychiatry. Also, the Reverend John S. [illegible] brings the light of theology and the history of religion to bear upon some of the problems of psychiatry as it goes through its current stages of development.

The remaining chapters are authored by so many renowned psychiatrists that they can not be listed here. In this able collection they place heavy emphasis on the education and image of the psychiatrist: present and future. Both are continuously influenced by the pressures of the changing culture.

[illegible], M.D.
Clinical Professor of Psychiatry
School of Medicine
University of Michigan
Ann Arbor, Mich.

NOTES

This past year represented the Mental Health Association's most influential in terms of federal legislation, appropriations, governmental operations and legislation. Here is a recap of the major breakthroughs in which MHA played a major role in 1973.

Renewal of the Community Mental Health Centers Act. This bill was passed over the Administration's determined opposition to end federal funds for start-up costs of new centers. For fiscal year 1973-74 alone, the renewal legislation has led the way to federal appropriations that will provide for the start-up of approximately 45 CMHC staffing grants (new centers).

Success in court action to force the Administration to release $6.7 million by Congress in the (1972-73) fiscal year 73 budget for use in starting community mental health centers. The release of this money will provide for 34 new staffing grants and grants for childrens' services.

Important increases in the new federal budget. For the first time in 3 years, MHA will have an official budget. The new budget for 1973-74 provides the additional $36.5 million for the 45 new centers mentioned above. In addition, there will be $11 million for new staffing grants for childrens' services, or approximately 67 new childrens' staffing grants. It also includes an additional $5 million for mental health research. An other important upgrading is represented by the manpower figures. The new bill provides $154 million for mental health manpower training, which is $17 million more than the Administration requested.

Success in releasing impounded funds for mental health manpower, research and state hospital programs. The Association brought suit to require the Administration to release funds impounded for manpower, alcoholism, and research programs. These funds had been appropriated by Congress in the previous budget (fiscal year 1972) but had been impounded by the Administration. As a result of pressures generated by this suit and by MHA in general, and through the efforts of other groups concerned about impounded funds, the Administration released the entire backlog. The total monies, all of which have been released, came to $120 million.

Mental health coverage included in the Administration's national health insurance proposal. The Council legislative office is in negotiations to include mental health coverage very close to that which has been in the Association's basic proposals for 3 years.

Victory in civil damage suit. MHA and the American Association for Mental Deficiency successfully led the movement to require it to apply minimum wage laws to persons providing employment in institutions where the employment is not necessarily related to the individual's therapy. This suit will have profound implications for ending exploitation of many patients, helping them gain self-respect through paying for some of the services they receive, and preparing many for productive outside employment.

[illegible] mental health centers.

[illegible] (see research still helps the Answer on p. 4).

[illegible] tigh of virility.

[illegible] Lane, Rockville, Md. 20852.

[illegible]

PUBLICATIONS

To order, write NAMH Publications Dept., 1800 No. Kent. St., Arlington, Va. 22209

Policy and Position Statements (*Free on request*)

- ☐ ABORTION
- ☐ CHILD DEVELOPMENT CENTERS
- ☐ CIVIL RIGHTS OF MENTAL PATIENTS
- ☐ THE DISADVANTAGED
- ☐ FACILITIES AND SERVICES FOR THE GERIATRIC MENTAL PATIENT
- ☐ FAMILY LIFE AND SEX EDUCATION
- ☐ HOMOSEXUALITY
- ☐ JOINT COMMISSION ON MENTAL HEALTH OF CHILDREN REPORT
- ☐ MANPOWER
- ☐ MARIJUANA
- ☐ MARRIAGE COUNSELORS
- ☐ MENTAL HOSPITAL/LABOR-MANAGEMENT DISPUTES
- ☐ MENTALLY ILL AND THE LAW
- ☐ NATIONAL HEALTH INSURANCE
- ☐ PASTORAL COUNSELING
- ☐ PSYCHOSURGERY
- ☐ RIGHT TO TREATMENT
- ☐ STANDARDS FOR LABOR PERFORMED BY STATE HOSPITAL MENTAL PATIENTS
- ☐ SUICIDE PREVENTION
- ☐ THIRD PARTY PAYMENTS FOR THERAPISTS

Pamphlets

- ☐ CAN MENTAL ILLNESS BE PREVENTED? $2.20 per C.
- ☐ CLERGYMAN'S GUIDE TO RECOGNIZING SERIOUS MENTAL ILLNESS. $10.00 per C.
- ☐ MINISTERING TO FAMILIES OF THE MENTALLY ILL. $10.00 per C.
- ☐ THE CLERGY AND MENTAL HEALTH. $10.00 per C.
- ☐ FACTS ABOUT MENTAL ILLNESS. $1.50 per C. Basic up-to-date statistics.
- ☐ FILM CATALOG. Free. Selected films for mental health education.
- ☐ GROWING UP AIN'T THAT EASY. $1.20 per C. Dos and Don'ts for dealing with the emotionally disturbed.
- ☐ HOW TO DEAL WITH YOUR TENSIONS. $7.50 per C.
- ☐ HOW TO INVOLVE ETHNIC MINORITIES AND THE POOR IN THE MENTAL HEALTH ASSOCIATION. $12.50 per C.
- ☐ INSURANCE IN MODERN MENTAL HEALTH CARE. $5.00 per C. Current thinking on insurance coverage for mental illness.
- ☐ THE HIGH COST OF MENTAL ILLNESS. $23.00 per M.
- ☐ CHILD ALONE IN NEED OF HELP. $2.30 per C.
- ☐ HOW TO DEAL WITH MENTAL PROBLEMS. $7.50 per C.
- ☐ HOW TO RECOGNIZE AND HANDLE ABNORMAL PEOPLE: A MANUAL FOR POLICE OFFICERS. 80¢ each or $55 per C.
- ☐ SOME THINGS YOU SHOULD KNOW ABOUT MENTAL AND EMOTIONAL ILLNESS. $2.00 per C; $16.35 per M.
- ☐ WHAT EVERY CHILD NEEDS FOR GOOD MENTAL HEALTH. $1.35 per M.
- ☐ WHEN THINGS GO WRONG. $9.00 per C.
- ☐ MENTAL ILLNESS: A GUIDE FOR THE FAMILY (revised edition). 80¢ each. Handbook for families of the mentally ill.
- ☐ NAMH PUBLICATIONS CATALOG. Free.
- ☐ WHERE YOU CAN FIND INFORMATION ON MENTAL HEALTH AND MENTAL ILLNESS: A BIBLIOGRAPHY. $2.25 per C.

Joint Information Service Publications

- ☐ CHILDREN AND MENTAL HEALTH CENTERS. $6.00 each.
- ☐ ELEVEN INDICES. $4.00 each.
- ☐ HALFWAY HOUSES FOR THE MENTALLY ILL. $6.00 each.
- ☐ MENTAL HEALTH ON THE CAMPUS: A FIELD REPORT $7.50 each.
- ☐ HEALTH INSURANCE FOR MENTAL ILLNESS. $2.50 each.
- ☐ PARTIAL HOSPITALIZATION FOR THE MENTALLY ILL: A STUDY OF PROGRAMS AND PROBLEMS. Cloth: $6.00 each; 4 or more copies $5.25 each. Paper: $4.00 each; 4 or more copies $3.50.
- ☐ PRIVATE PSYCHIATRIC HOSPITALS: A NATIONAL SURVEY. $3.00 each.
- ☐ REHABILITATING THE MENTALLY ILL IN THE COMMUNITY. $6.00 each.
- ☐ THE COMMUNITY MENTAL HEALTH CENTER: AN INTERIM APPRAISAL. Cloth: $6.50 each; 4 or more copies $5.25 each. Paper: $4.00 each; 4 or more copies $3.50.
- ☐ THE MENTALLY ILL OFFENDER: A SURVEY OF TREATMENT PROGRAMS. Patricia K. Scheidemandel and Charles K. Kanno. $2.00 each.
- ☐ THE PSYCHIATRIC EMERGENCY: A STUDY OF PATTERNS OF SERVICE, 1966. $2.50 each; 5 or more copies $2.00 each.
- ☐ SALARY RANGES OF PERSONNEL EMPLOYED IN STATE MENTAL HOSPITALS AND COMMUNITY MENTAL HEALTH CENTERS, 1970. Patricia L. Scheidemandel and Charles K. Kanno. $4.00 each.
- ☐ LEGAL SERVICES AND COMMUNITY MENTAL HEALTH CENTERS. Henry Weihofen. $2.00 each.
- ☐ THE STAFF OF THE MENTAL HEALTH CENTER: A FIELD STUDY. Hardcover: $6.00 each; 4–9 copies $5.25; 10 or more copies $4.75 each.
- ☐ THE TREATMENT OF ALCOHOLISM. $3.00 each.
- ☐ TREATMENT OF DRUG ABUSE: A STUDY OF PROGRAMS AND PROBLEMS. $7.00 each.

(Bulk orders available from Publications Department, American Psychiatric Association, 1700 18th St., N.W., Washington, D.C. 20009. Discount for bulk orders.) The Joint Information Service is sponsored by the National Association for Mental Health and the American Psychiatric Association.

THE NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.

Founded by Clifford W. Beers in 1909, the National Association for Mental Health is a voluntary citizens' organization working for the improved care and treatment of the mentally ill, for improved methods and service in research, prevention, detection, diagnosis and treatment of mental illness, and for the promotion of mental health.

Research and Cookie Jars Are A Lot Alike.

You never know what you'll find until you look. Take mental illness, for example. You might say that's biting off quite a chunk. But dedicated researchers are doing just that — and coming away winners.

It used to be that a person with schizophrenia — the most prevalent mental crippler — faced a 50-50 chance of being laid up in the hospital for more than a year. No more. Today, his chances for release within a year are four in five, provided he enters an adequately staffed hospital.

Encouraging these research efforts is the National Association for Mental Health — the only nationwide citizens' organization to do so.

Your mental health association is striving to make a difference in the quality of mental health research conducted locally.

Join and Support Your Mental Health Association
Citizens Who Do Make A Difference

Spring 1974.

INSIDE JACK RUBY

The never-before published Psychiatric Examination of One of the key figures in the aftermath of President Kennedy's assassination

Our responsibility is not discharged
by the announcement of virtuous ends.

John F. Kennedy

CONTENTS

Spring 1974 • Volume 58, Number 2

2 **Notes** *developments*
Richard W. Flanagan

4 **Letters** *reaction*

5 **Commentary** *editorial*
Richard C. Allen, J.D.

6 **Dialogue in Dallas** *report*
Werner Tuteur, M.D.

11 **The State Hospital: What Is Its Future?** *article*
Hans M. Schapire, M.D.

17 **A Clear and Present Danger** *article*
Thomas S. Szasz, M.D.

21 **Bent to a Single Cause** *essay*
Bill Perry, Jr.

25 **Turning a Problem Inside Out** *article*
Eric W. Fine, M.D.
Pascal Scoles, M.S.W.

28 **One Vicious Circle** *article*
Joel Freedman, M.S.W.

32 **Pattern for Change** *article*
Ralph G. Hirschowitz, M.B.

36 **Model of a Program** *article*
Steven S. Sharfstein, M.D.
Farrokh Khajavi, M.D.

40 **Books** *reviews*
Gene Usdin, M.D.

44 **Publications**

I was one of the first two men on the moon, but the most hazardous part of my journey began with my return to earth. I suffered a mental depression requiring hospitalization and professional care.

Why am I telling you this? As National Mental Health Chairman, I want to stand up and be counted and *ask* you to support a vigorous program to find the answers to the cause and cure of mental illness.

Please—you can help. Give today.

Dr. Edwin E. (Buzz) Aldrin, Jr.
National Mental Health Chairman

PHOTO CREDIT NASA

6

21

28

Model 36

The National Association for Mental Health, Inc. Editorial Office: 1800 North Kent St., Rosslyn, Arlington, Va. 22209. Circulation Department: 49 Sheridan Ave., Albany, N.Y. 12210. Rates: $10 per year (Canada, $10.25; other countries, $10.50). Single copy, $3.

Printed in Baltimore, Md. Second class postage paid at Albany, N.Y., and additional entry office.

Credits:
6—UPI; *11*—H. Armstrong Roberts; *21, 22, 23, 24*—Michael T. Goorevitz; *28, 29, 30, 31, 36*—Day Walters.

NOTES

A number of late-breaking news items cross my desk every time we go to press with "Notes." In sifting through the developments to be published for this issue, I was immediately struck by the coincidence in timing related to some of them...mental incompetency, violence, terrorism. With the "unearthing" of Dr. Werner Tuteur's psychiatric examination of Jack Ruby (see "Dialogue in Dallas" on p. 6) after almost 10 years, the irony is apparent. Even though there is no direct relationship to the subject of that revealing report, such notes do seem to indicate a continuing, if not increased, interest in these areas of human behavior.

Most persons judged to to be mentally incompetent to stand trial for alleged crimes are treated more harshly and unfairly than those who are formally brought to trial for similar infractions of the law. This is one of several findings in a major new study exposing a variety of abuses that attend the legal procedures to stand trial. The document, entitled "Misuse of Psychiatry in the Criminal Courts," was recently released by the Group for the Advancement of Psychiatry (GAP), an organization of 300 distinguished psychiatrists. Copies of the study may be obtained at $3 each from the GAP Publication Office, 419 Park Ave. South, New York, N.Y.

Long-acting tranquilizers, such as phenothiazine, used with hysterical or violent psychiatric patients in hospital emergency rooms interfere with subsequent proper treatment and diagnosis by psychiatrists. That's the finding of Dr. Beverly Joyce Fauman, a University of Chicago psychiatrist. Addressing the American College of Emergency Medicine in Chicago recently, Dr. Fauman stated that drugging a patient may conceal an organic brain syndrome and make him "even more disoriented, frightened and out of control." On the other hand, she said, "Physical restraint has minimal hazards when applied with firmness in adequate amounts and for control rather than for punishment."

You, the newspaper reader or TV viewer, are the real person terrorists want to "get." According to Dr. Lawrence Zelic Freedman, who has spent the past 20 years studying aggression and violence, the terrorist is more concerned with the impact on a third group or audience than the destructive effect on the immediate victim of the assault. Says Dr. Freedman, "Terrorists see themselves as taking part in dramatic, symbolic, and even magical acts." Also, the typical terrorist is a believer in absolute values, and that these values justify in his or her mind any form of reaction against prevailing values.

Society holds strange attitudes toward the victims of violent crimes. "In fact, states psychoanalyst Martin Symonds, "there seems to be a marked resistance to accept the accidental nature of victim behavior." Addressing the Association for the Advancement of Psychoanalysis in New York recently, Dr. Symonds added that this resistance to hold victims blameless is rooted in antiquity. An expert in the newly developed field of victimology (victim behavior), he has been actively involved in promoting psychological understanding of those people most victims find most unsympathetic--the police. Dr. Symonds was a policeman prior to becoming a physician and psychoanalyst.

Film violence may increase a child's toleration of real-life aggression, report two Florida psychologists. Drs. Ronald S. Drabman and Margaret Hanratty Thomas of Florida Technological University (Orlando) recently discovered that children who had just finished watching a Hopalong Cassidy film filled with violence were considerably more tolerant of watching two younger children fight than those children who didn't see the film. The results were obtained in an experiment with 42 third and fourth graders.

A universally accepted definition of death is being called for by the American Bar Association. ABA President-elect James D. Fellers said that death must be defined "not only in terms of when someone's organs are legally available for transplantation, but also in terms of probating wills and determining the cause of death in a criminal action." According to Fellers, the dilemma lies in the several ways now that life can be said to have "ended"--cellular death, physiological death, brain death and metaphysical death.

The Association of Mental Health Administrators will hold its national conference this year in Denver from October 3 through 5. The theme of the conference will be "Administering Mental Health Programs in a Rapidly Changing Care System." For more information, write: David R. Steindorf, Ph.D., AMHA Conference Committee, 7400 W. 183rd St., Tinley Park, Ill. 60477.

Laughing is a serious matter. Such is the contention of a New York University clinical instructor, Dr. Luis R. Marcos. Notes Dr. Marcos, "... laughter arises from conflict--conflicting wishes, feelings or incongruous thoughts. In therapy, laughter is also used by the patient with a defensive purpose, as he or she attempts to cover up a painful issue."

A major study of male homosexuality has found "no major differences in psychological well-being between homosexuals and the general population." The study was by two sociologists, Morton S. Weinberg and Colin J. Williams, under the auspices of the Institute for Sex Research. It represents the first extensive field study of a large group (2,400) of homosexuals who were not psychiatric patients. Coming on the heels of the American Psychiatric Association's recent decision to remove homosexuality from its list of mental disorders, the study will be published May 30 by Oxford University Press under the title "Male Homosexuals: Their Problems and Adaptations." Dr. Judd Marmor, APA president-elect, terms this latest "Kinsey Report" a "substantial contribution."

Health and the adolescent was the subject of a recent conference, sponsored by NIMH and the HEW Bureau of Community Health Services. Among the recommendations to come out of the conference were • the necessity of a network of health services for adolescents and • the need for major reform in a legal system that presently discriminates against adolescents because of their age. Underlying these areas was the implicit need to involve adolescents in planning for their own adequate health care delivery system.

MOVING? PLEASE NOTIFY US 4 WEEKS IN ADVANCE

Attach mailing label here, fill in new address below and send to: MH SUBSCRIPTION OFFICE, 49 Sheridan Ave., Albany, N.Y. 12210.

Name_____

New Address _____

City _____ State_____ Zip_____

TO WRITE ABOUT YOUR SUBSCRIPTION: Change of address, billing adjustment, complaint, renewal—address: MH SUBSCRIPTION OFFICE, 49 Sheridan Ave., Albany, N.Y. 12210. (Attach present address label in space provided. If you are receiving duplicate copies, please attach both labels.) This will help us identify you quickly and accurately.

TO ORDER A NEW SUBSCRIPTION: Check box ☐ and use form above. Mail to MH SUBSCRIPTION OFFICE at the address given. Or for faster service and attention, you can simply call (518) 436-9686. Subscription rate: U.S., 1 year $10.00; In Canada, $10.25; other countries, $10.50.

TO WRITE ABOUT EDITORIAL CONTENTS: Address: MH, 1800 N. Kent St., Arlington, Va. 22209.

LETTERS

HIGHEST COMPLIMENT

Dear Sir:

I commend you and your staff for the fine quality of *MH*. I found the magazine to be very attractive and the articles very interesting.

Even though I have access to *MH* in the office, I've decided to subscribe to it myself. That is the highest compliment I can make.

JANE FORD
State Mental Health Educator
Department of Public Institutions
State of Nebraska
Lincoln, Neb. 68509

HOSPITAL CLOSINGS

Dear Sir:

In your winter issue under COMMENTARY, you refer to the closing of state mental hospitals in California.

Enclosed is a copy of a report submitted to the Legislature in response to an Assembly Resolution. As you will see, the report indicates that the 11 existing state hospitals in California will continue to operate for the foreseeable future as part of the balanced treatment system for the care of the mentally disordered and developmentally

ANDREW G. ROBERTI
Deputy Director
Department of Health
State of California
Sacramento, Calif. 95814

ISSUES AND ANSWERS

Dear Sir:

What I'm writing to ask is will you please resist temptations to jump into areas which may or may not be closely related to the well-being of the mentally ill or mental health. I'm referring specifically to your yielding to the temptation to make comment about Watergate and the President (COMMENTARY, Fall *MH*).

It's your privilege to think anything you want about any political matter, but I don't think any staff member or any volunteer of the National Association should have the privilege of using its publications to expound a position on a political issue unless that issue is very specifically a mental health one. By no stretch of the imagination can you say that the well-being of the mentally ill was the issue, in any sense, in the Watergate Affair.

JOSEPH R. BROWN
Executive Director
Mental Health Association
in Indiana
Indianapolis, Ind. 46202

COMMENTARY

Richard C. Allen, Editor-in-Chief

The United States District Court for the District of Columbia, whose able and distinguished Chief Judge, John A. Sirica, has been so prominent in the cases arising out of Watergate, is again in the news with three decisions of great interest to our Association.

In the first, in which NAMH joined with the American Association on Mental Deficiency and the American Federation of State, County and Municipal Employees in behalf of three patients, Judge Aubrey E. Robinson, Jr. ruled that patient-workers in non-Federal institutions are covered by the minimum wage and overtime compensation provisions of the Fair Labor Standards Act, and directed the Secretary of Labor to enforce these provisions where patients are, in effect, exploited by being required to perform non-therapeutic and inadequately compensated labor. The decision will be an important one in the Association's efforts to end the practice of patient "peonage."

Contemporaneous with that decision was the call by J. Stanley Pottinger, assistant attorney general of the U.S. in charge of the Civil Rights Division, for new legislation that would enable the Department of Justice to initiate action in cases of denial or abridgement of the civil rights of mental patients. The Department is presently limited to intervention in cases brought by others. Within that limitation, it has been a potent factor in such cases as the Alabama and New York "right to treatment" cases, and its widened interest in supporting the rights of the mentally ill and mentally retarded will truly help to "make a difference."

In the second of the D.C. District Court cases, Judge Thomas A. Flannery ordered the Nixon Administration to release approximately $160 million in "impounded" funds, and restore them to the Congressionally mandated mental health and alcoholism programs for Fiscal 1973 and 1974. On a related front, the Association continues to protest the severe cuts in mental health services and research and training programs in President Nixon's 1975 budget. Commenting on the proposed budget, American Psychiatric Association President, Dr. Alfred Freedman, observed: "It is puzzling how the Administration can, on the one hand, promote national health insurance, and on the other, strip the nation of crucial resources to run such a vast program."

The third case involves a decision by District Court Judge Gerhard Gessell, declaring illegal Federal regulations allowing government funds to be used to finance sterilizations of minors or mentally incompetent persons. Judge Gessell ordered the regulations rewritten to "insure that all sterilizations funded . . . are voluntary in the full sense of that term, and that sterilization of incompetent minors and adults is prevented."

□

In our Fall, 1973, issue on corrections, several contributors commented on "behavior modification" programs in prisons. Since that issue appeared, the Law Enforcement Assistance Administration(the funding arm of the U.S. Department of Justice) has announced that funds will no longer be provided to state correctional agencies and others for medical research, surgery, behavior modification, or chemo-therapy for the purpose of changing the behavior of inmates. And the U.S. Bureau of Prisons has terminated its controversial Project START, a behavior mod program. The decision came after a court-appointed panel of experts termed the program "punitive, not rehabilitative."

□

A new organization, under the direction of *MH* contributor Dr. Peter R. Breggin, will assume a watch dog role over the use of psychosurgery, drugs and behavior modification in a way threatening to personal and political freedom. Called the Center for the Study of Psychiatry, it will provide information and consultation services to agencies and groups concerned with oppressive use of psychiatric techniques. The CSP address is 1827 19th Street, N.W., Washington, D.C. 20009.

□

MH Editor/Designer Dick Flanagan has written a booklet entitled *A Bright Future: Your Guide to Work*. It provides practical tips to persons who have had a mental or emotional illness, and now need to find a job. Copies are available free of charge through NAMH or from the President's Committee on Employment of the Handicapped (1111 20th Street, N.W., Washington, D.C. 20210). ■

How mentally competent was Jack Ruby to stand trial for the murder of accused Presidential assassin Lee Harvey Oswald on November 24, 1963? The answer to this and other questions about Ruby's character are revealed in the following psychiatric examination of him by Dr. Werner Tuteur. Except for minor editorial changes, the report, as it appears here, is essentially the same as that submitted to Ruby's attorneys to instruct them about his mental condition and competency to stand trial. The examination was performed in 1965, the year following Ruby's original trial and death sentence in Dallas, in preparation for a new trial to take place in Wichita Falls, Tex. A change of venue had been obtained by his new lawyers, one of whom was Elmer Gertz of Chicago, on whose request Dr. Tuteur had traveled to Dallas. Ironically, a competency hearing had never taken place prior to Ruby's original trial. And as things turned out, he never lived to benefit from one—dying from lung cancer in January 1967, one month prior to when legal proceedings were scheduled to begin.

DIALOGUE IN DALLAS

PSYCHIATRIC EXAMINATION OF JACK RUBY
by Werner Tuteur, M.D.

Dates of Examinations: July 12th, 13th, 14th and 15th, 1965.

Place of Examinations: Dallas County Jail, Dallas, Texas.

Reason for Examinations: The purpose of this examination is to determine the present state of competency of the defendant.

Introduction: Ruby's history covering his early development, his general activities, the reason for his arrest and trial have been extensively covered by many news media.[1] They will not be repeated here.

Length of Interviews: The first interview lasted for 2 hours and 15 minutes, the second for 1 hour, the third for 1 hour-and-a-half, and the fourth for half-an-hour. All interviews took place in an examining room containing a table and two chairs, located on the same floor as the defendant's quarters. For reasons of proper ventilation, the door was kept somewhat ajar.

Attitude and Behavior: The initial encounter with Mr. Ruby was of interest. The interview room was not immediately available and our mutual introduction took place in the hall. Ruby had been informed by his sister about my pending arrival. He shook hands willingly and was friendly. He was disappointed that we could not immediately enter the examining room.

Later, when we entered the interview room, Ruby rather circumstantially and ritualistically placed the only two chairs close to each other, facing the wall. He placed them at a considerable distance from the table, since he was convinced of the presence of a microphone immediately below the table. All four interviews were practically conducted in a whisper. Ruby became considerably upset when I greeted him during the second interview, using a normal tone of voice, asking him how he had slept. He responded by saying, "I told you not to talk so loud, since everything here is being recorded. . . ." I was always sitting to Ruby's right and he would whisper into my left ear.

His attitude of secrecy and circumstantiality prevailed during all of our meetings. Yet, Ruby was by all means friendly, but not always cooperative. He was to be the one to do the talking by giving endless orations. Attempts at interrupting him were met with, "Please hear me out, you must listen to me." He then proceeded by indicating that he was sane and that his mind was functioning adequately. He promised that after having given such proof, he would make me acquainted with a conspiracy which I was to guard with the utmost secrecy. He had already mentioned this conspiracy in the hall.

At the end of the third interview, he insisted he was going to obtain the book Who Killed Kennedy?, written by the Englishman Buchanan, from another inmate for me. I replied that I would neither remove from nor introduce anything into this building, to which he reacted very angrily, asking me never to return. When I, nevertheless, reappeared the next morning, he was pleased to see me again. Ruby invited me to dinner during the first interview, which took place during late afternoon hours. As it happened, he became so engulfed in the examination that he forgot about his own dinner.

Dr. Tuteur is Associate Clinical Professor of Legal Psychiatry at Loyola University, Chicago; and consultant to the Federal District Court, Northern Illinois, Eastern Division, as well as the Cook County Circuit Court, both in Chicago. He is also in private practice of psychiatry and neurology.

Emotional Tone: Throughout the examinations Mr. Ruby remained depressed and at times agitated. There was also undue excitement, and there were suicidal preoccupations. The two suicidal attempts that he had committed since confined to his present residence were discussed. He gave as a reason that he did not want to be tortured to death. There were silences during the interviews, when Ruby would hold his head in his hands and would carefully listen to incidental noises, such as the squeaking of a door or the shuffling of feet by other inmates. Moving his chair somewhat, he would then look at me with a mournful expression and say, "Do you hear crying?". He was convinced Jewish women and children were being slaughtered right there and then.

This came to a climax when, during the last interview, a crew of plumbers began to dismantle a piece of equipment with heavy hammer blows, creating a great noise. Here Ruby had found "proof" of his allegation of the manslaughter of Jews on premises. At other times he would repeatedly say with great feeling, "What a terrible thing I did by killing that man. . . ."

Mental Content: Presently Ruby is very much preoccupied with his death sentence and his fear of dying. This became particularly pronounced when I made preparations to leave the interview of 1 hour-and-a-half. Both of us had noticed an attorney who obviously needed the examining room for a client. Ruby exclaimed, "You are leaving a man who has been sentenced to death . . .?" Practically all his statements were colored by marked fear. He considers himself the victim of a conspiracy and was "framed" to kill Oswald, so that Oswald could never say who made him kill President Kennedy.

This "framework," of course, is very complicated and must be guarded with the
8 greatest secrecy. It involves the strip teaser, his employee who, on the fatal morning of November 24, 1963, "made him go to Western Union to wire her money." She had timed it just right so he had to shoot Oswald. It involves also high government agencies and his attorneys whom he considers to be members of the plot. They wanted then and want now to harm him seriously. It is in these areas where the patient's grasp of reality is completely absent. Such ideations are fixed false beliefs, where argumentation and even proof of falsehood are in vain.

Ruby is extremely sensitive in matters referring to antisemitism; there are many fixed false beliefs in this area. Usually there is a fragment of truth in his false ideas. However, this fragment is then magnified and misapplied by the patient. It so happened that on July 12, 1965, the day of the first interview, the Dallas Morning News had published a news item referring to recent outbreaks of antisemitism in Bamberg, Germany. Ruby, an avid reader, had read the item.

Characteristically, it acted upon his vast and unlimited system of fixed false beliefs like a match on a keg of dynamite. Now he was convinced that Jewish women and children were being killed in the adjoining room and all over the United States. Another example completely void of logic and showing poor critical thinking, if any, was the following: "They are trying to make another Dreyfuss Affair* out of me."

The only parallel between Ruby and Dreyfuss is that they both belong to the Jewish faith. Dreyfuss was not involved in any antisocial activity. He finally stated that there was absolutely no difference between the United States, Auschwitz, Treblinka and Maidanek, all infamous Hitler extermination camps. What

* Captain Dreyfuss was an officer in the French peacetime army. During the 1890s he was falsely accused of high treason and espionage, which he had never committed. Nevertheless, he was tried, found guilty, dishonorably discharged and exiled. Several years later, after a new investigation, he was found innocent and fully rehabilitated.

Ruby is doing here is popularly called applying "mental shortcuts." It is a sign of severe malfunctioning of his mind. According to him, all Jews are presently being tortured and killed on account of his misdeed. He is convinced that his family has been annihilated on account of him. Repeatedly, he asked me to call members of his family—he provided me with the telephone numbers in writing—to convince me that they were dead.

Again his false beliefs expanded rapidly: I was also to call New Yorkers bearing Jewish sounding names, which I was to select from the telephone book, and convince myself that they were dead because "there will be a goyish (gentile) voice" answering the phone, making evasive statements about the whereabouts of these people who, according to Ruby, had been murdered. "Call Senator Goldwater and have him make a geschrei (noise) to save the Jews." Most members of the government are mamsorim (literally translated: illegitimate children, bastards). As long as they have the Army behind them, they can do as they please.

He considers the present government antisemitic, because it sent arms to Egypt. When reminded that even Roosevelt was friendly to the Arabs during World War II, to provide oil for the United States, he would not listen to reason. Here again, his lack of logic becomes very apparent. The noises made by trains and planes are frequently heard in the jail, since it is located in the vicinity of the railroad station and the airport. Ruby is convinced that the sole function of these trains and planes is to remove Jews to death camps.

The call from Fort Worth on the morning of November 24, 1963, directing him to go to the Western Union, was his "nemesis." He then drew a sketch of the downtown street system of Dallas, demonstrating how he could or should have taken another route which would have delayed him and would have prevented the murder of Oswald.

Ruby insists he knows who had President Kennedy killed. They want him (Ruby) to be insane so no one will believe his story. For him, the assassination was an act of overthrowing the Government. Then followed, as is so frequently the case in disorders of this nature, a discourse on his supernatural powers. Ruby is not able to follow a logical stream of thought, and he frequently jumps from one subject to another.

At one time he states that the war in Vietnam is merely a diversion maneuver, distracting the American people from the things that were happening within the United States, such as the mass slaughtering of Jews. Then he suddenly related that he cannot possibly divulge how he was framed into killing Oswald. He becomes annoyed by questions asking for explanations, because he cannot produce them. A veil of secrecy then descends on the statements he has just made.

There are, of course, many islands of reality left in Ruby, as is so frequently the case in his particular mental illness. It must be remembered that only a part of his person is insane at this time. He relates well about his early development and other circumstances available from the Warren Report. He avidly reads the newspaper every day and carries on a reasonable conversation as long as he or others avoid his sensitive areas where the mental illness is located: antisemitism, the murder of Oswald, and the conspiracy regarding the Presidential assassination. His judgment and decision making are greatly impaired, as is his critical thinking.

He did not fail to warn me and instruct me that I would be followed the moment I would leave the jail and that my phone would be tapped henceforth. He closed the series of interviews with the statement, "I am doomed. I do not want to die, but I am not insane. I was framed to kill Oswald."

Additional Comments: My report would be incomplete without considering the possibility of malingering. Here are the reasons why I think that Ruby is suffering from a genuine mental illness:

- His false beliefs are consistent. He has expressed them to others before I had an occasion to examine him. They are free of contradictions with regard to the content, and they persist. They were especially pronounced when I saw him after he had just been awakened but was still sleepy and drowsy. A malingerer needs all his faculties to "display" his alleged mental illness, and one would expect such an occasion to see the patient gather himself and make an attempt to concentrate on his "faking." This was not the case. The false beliefs flowed better than ever on that day.
- The average malingerer conceives mental illness as something comical and clownish. Such behavior was completely absent in his case.
- The fact of denial of the illness is a typical symptom of the very condition from which Ruby suffers. ("I am not insane, but everyone else is. . . .") Yet, a very shrewd malingerer might use such denial as a means of "faking." This technique of course, involves a great risk, resulting in the fact that people might actually believe the patient is not "ill." I do feel that his denial is genuine and a part of his mental disturbance.

Diagnosis: Jack Ruby is suffering from schizophrenic reaction, paranoid type. There are sufficient elements of unreality within his thinking that justify this diagnosis. It may be stated once more that in such instances only a part of the person succumbs to mental illness. To use a popular comparison, he does not function on "all cylinders."

10

The onset of paranoid schizophrenia is slow and insidious. It is felt that in Ruby's case it has been existing for at least 4 to 15 years. This is borne out by his hostilities, his suspicions, his violent behavior, and his extreme vulnerability and sensitivity long before the Presidential assassination and its ramifications. There was a mental breakdown in 1952.[2] Further, his mental illness has established itself by now to such a severe degree that it must have existed for years. Such conditions are treatable, and Mr. Ruby at this time is in urgent need of such treatment.

Conclusion: It has been stated above that Ruby could not differentiate between friend and foe. An indication of this was his extreme hostile attitude toward his lawyers, whom he felt would harm him. This is an expression of his mental illness, the nature of which further renders him unable to comprehend instructions and advice, to make decisions after advice, and to follow testimony for contradictions and errors. He is not mentally equipped to testify or to be cross-examined, and it is doubtful whether he can tolerate the stress of trial. Thus, he is incompetent to stand trial.

Bibliography:

1. Report of the Warren Commission on the Assassination of President Kennedy, as prepared by the New York Times. Bantam Books, Inc., New York, New York, 1964, p. 688 ff.
2. Ibid., p. 701

THE STATE HOSPITAL

WHAT IS ITS FUTURE?

By Hans M. Schapire, M.D.

PRONOUNCEMENTS about the future or non-future of the state mental hospital have not always been based on entirely rational considerations. I say this because overcrowding, understaffing, underfinancing, and overutilization have combined with the state hospital's organization along autocratic lines to produce a stigma in the eyes of patients, their relatives, and the general public that has not been overcome yet, despite substantial changes in recent years.

Even more significant are the emotional reactions to the image of the old-type custodial institution that carry over, in a somewhat inappropriate fashion, to anything still identified as a state hospital. Some of the most progressive mental health professionals react to the very existence of a state hospital as a surgeon reacts to the presence of a cancerous growth; it must be eliminated or eradicated.

Other groups bring different considerations. For instance, economy-minded legislators and politicians emphasize that with the evolvement of community mental health centers, there is no further need for state hospitals as primary providers of mental health services. This takes the form of a solemn conviction based on no evidence whatever.

On the other hand, there are vested interests in communities where state hospitals have provided an important tax base and a source of income for hundreds or thousands of workers. In fact, the staffs of these hospitals are often so anxious about their own future that they become convinced that the state hospital, as an essential component of the mental health care system, should not be tampered with.

In contrast to these approaches, I would, first of all, point out that state hospitals can no longer be viewed as homogeneous in nature. This is quite a different situation from that which existed some 10 years ago, when practically all of them fitted a certain stereotype. They were properly depicted as total institutions, with almost total isolation from the community. Yet, a great many of them no longer fit this picture, owing to certain changes that have taken place. Let's look at some of them.

To begin with, there's no question that most of the important changes in our state hospitals were preceded by certain attitudinal changes, primarily among some enlightened leaders in the mental health field. These new leadership attitudes emphasized • the fostering of independence rather than dependence on the part of patients, • the introduction of democratic principles into the hospital care system rather than reliance on autocratic, paternalistic methods, • the conversion of a closed society into an open one, and • the freeing of the dormant human potentials among patients and staff alike.

Many of the most significant and successful programs of the Sixties are based on these principles. Thus, the open hospital, the geographic decentralization of the hospital, the active search for alternatives to hospitalization in the patient's community, and affiliation with community clinics and centers of higher education all derive from the decision that the hospital will no longer function in isolation. Instead, it will link up with all relevant components of the community it is supposed to serve.

It is this conversion from a closed to an open system that is the precondition for all efforts to develop an integrated and unified system of mental health care delivery. By the same token, the introduction of democratic principles into the state hospital has led to such developments as the therapeutic community, patient government, staff participation in the planning and management process, and has made possible the breaking up of monolithic institutions into semiautonomous units with actual treatment staff making decisions which in the past had been reserved to a few people at the top of the organizational pyramid.

This change, in and by itself, has led to the freeing of vast human resources that had lain dormant within the old autocratic institution. By training ward attendants to become skilled psychiatric technicians, thousands of them were converted into an army of responsible caretakers, thus increasing the potential for successful treatment of the mentally ill by an exponential factor.

FINALLY, recognition that patients needed to be prepared for independent living in the community instead of being merely taught to adjust to non-therapeutic demands of the institution, has led • to emphasis on the patient's remaining assets rather than on his liabilities; • to the establishment of various anti-regressive measures, such as the therapeutic community and the day hospital; and • to the encouragement of voluntary admissions and a fostering of the idea that the patient, in spite of his illness, must to a large extent retain responsibility for his actions.

Some hospitals have carried the implementation of these principles further than others. This has depended on such factors as professional leadership, location, historical accident, and a whole set of external circumstances that vary from case to case. Thus, it was particularly fortuitous that the Fort Logan Mental Health Center was created at the exact time when the report of the Joint Commission on Mental Illness and Health was published.

It enabled this institution to incorporate into its operation the best thinking of the past decade, without having to undo the mistakes of the past. More traditional state hospitals

Dr. Schapire is currently with The New York State Department of Mental Hygiene, Albany, N.Y.

had to start with a large accumulation of chronic patients and with an entrenched institutional culture resistive to changes which threatened long established relationships and organizational patterns. In spite of these difficulties a large number of state hospitals have moved great distances along the lines indicated.

In considering what factors may determine a particular hospital's role and the ways in which state hospitals can become an integral part of a total service delivery system, it may be useful to distinguish among three types of state hospitals.

☐ The first of these is the state hospital located in a metropolitan area, and I would suggest that its future utilization be based on the following principles and considerations.

• Avoid unnecessary duplication of services and facilities. If the services and facilities provided by the state hospital are easily accessible to the consumer, it would be difficult to justify the establishment of additional facilities and of the same services in the state hospital's service area. Under such circumstances, the portion of the state hospital serving this particular area should become part of a community mental health center. Should it become necessary to replace a hospital building, the question of possible relocation into an area better meeting community needs should be carefully considered.

• If similar services are being provided by two or more agencies, including a state hospital, the agencies concerned should launch a joint planning effort—with prominent inclusion of consumer groups—and determine which agency should provide what service, which services should be dropped, and which services should be offered by more than one agency. Such an amalgamated operation would foster recognition and closure of gaps in services.

• Utilization of the state hospital's resources does not necessarily or exclusively mean utilization of beds. It should mean primarily utilization of special skills developed by state hospital staff in dealing with those patients who, as a result of mental illness, are chronically disabled. One important role of the state hospital is to further refine these skills and to use them in creative and innovative programs, wherever possible in a community setting.

• The state hospital must not become a dumping ground for those patients of community mental health centers whose treatment seems not particularly rewarding. Depending on local conditions and prejudices, patients at risk of being dumped into the state hospital system are members of minority groups, the poor, the mentally retarded, alcoholics and other addicts, the aged, some adolescents, and the uneducated.

In general, staffs of community mental health centers are more aware than are the more traditional agencies of their responsibility to meet the mental health needs of all citizens, including those in the high risk groups just mentioned. However, in a situation where limited financial and manpower resources make it impossible for any center to provide truly comprehensive service, it is inevitable that various processes will be at work to give some target groups preferential treatment over others. For that reason, mechanisms must be built into the referral system to minimize this danger.

Transfer to a state hospital should be based on sound professional judgment. The decision should be made jointly by staff of the referring agency and of the state hospital.

After the transfer has been effected, the staff of the community agency should maintain contact with the patient and with the state hospital treatment staff. The notion of *once a state hospital patient, always a state hospital patient* must be actively resisted. Policies must make it explicit that each patient *is* a member of the community and, as such, his care is a responsibility of the community. In this instance, the community merely utilizes the resources of the state hospital for a specific purpose until a different community resource is indicated.

It has often been stated that certain services for specific groups can be provided only in a state hospital setting. Such target groups include the criminally insane, children, adolescents, alcoholics and drug addicts, geriatric patients, and the minimally educated who do not take well to one-to-one talk therapies. It should not come as a surprise that this list shows considerable overlap with those population groups who are frequently victims of the aforementioned dumping syndrome.

Each high risk group must be carefully evaluated in terms of its actual need for state hospitalization. It would appear that the overwhelming majority of these patients can effectively be cared for in a community setting, provided adequate facilities and diversified services are made available for this purpose. For example, we don't know how many children would need care in a longer term residential facility if there was a full spectrum of children's and family services available in the community. If we had the answer to that question, we still would have to ask what services a state hospital could provide that could not be provided in a local residential treatment center.

Following the same logic, how many geriatric patients would need to be removed from their own homes if the community provided the kinds of support necessary for an elderly person to maintain himself in the community with dignity? It can probably be demonstrated that the lack of community supports actually creates the conditions that lead to serious mental breakdown

and emotional disturbances among the elderly. However, it has been shown that even in the absence of ideal community conditions, state hospitalization of the elderly can be reduced to a minimum.

Fort Logan, serving a population of more than 1 million people, has never more than 30 geriatric 24-hour patients and a handful in day care. Since the inception of its geriatric program in 1966, not a single person over 65 residing in the Denver metropolitan area has been admitted to Colorado State Hospital in Pueblo. At least one half of the staff time of Fort Logan's geriatric services is devoted to work in the community, to developing alternative placements, supporting patients and their families and in consultation with community caregivers. Fort Logan's experience confirms that of others who find that effective pre-admission screening of the elderly can prevent much unnecessary hospitalization and can simultaneously serve as a powerful stimulus for the development of more adequate community services.

RECOGNIZING Fort Logan's success in minimizing the need for hospitalization of the elderly, one can't help asking whether even this amount of hospitalization needs to be provided by a state hospital. Couldn't the same service be provided as part of a community mental health program, utilizing the facilities of a centrally located general hospital and applying the principles of care developed at Fort Logan and elsewhere?

The point I am trying to make is that there is no reason in principle why state hospitals should continue to admit geriatric patients. I say admit because I realize that there are many chronic state hospital patients who have grown old in the hospital and for whom the hospital may represent family and community. In such cases, one must raise the question for each individual whether any community setting can provide him or her with greater happiness and satisfaction than the accustomed hospital setting.

Our conviction that community care is better than institutional care should not lead us to the point where we add insult to injury by adding the new pain of separation from an accustomed environment to the old crime of institutionalization. Hopefully, as fewer and fewer people are subjected to this treatment, there will be less and less opportunity for patients to grow old in a mental hospital and we won't have to face this painful dilemma.

In general, it is safe to say that present facilities and services of community mental health centers are inadequate to maintain some patients of the various categories mentioned for the length of time required to obtain optimal results. This is particularly true for children, for drug addicts, and for the mentally disordered offender.

In considering the future of the state hospital located in a metropolitan area we must also consider its potential for training and research. Many such hospitals are currently providing an important resource for the training of mental health professionals, paraprofessionals, and community caretakers. However, these efforts are usually viewed as secondary in importance when measured against the primary mission of the hospital in providing service to the mentally ill.

As the service functions of the hospital become more limited in scope, and an ever larger percentage of patients are cared for in a variety of community agencies, it is suggested that the training and research component of the state hospital be expanded. One could even consider the total conversion of the hospital into an institute for training and research in community mental health.

SUCH an institute would provide basic training in the principles and practice of community mental health, and train students in the four core disciplines as well as caregivers on the firing line. Basic students from the core disciplines would be assigned to the institute for a block of time and receive full credit for their required training. There would be classroom teaching and field experience in participating community mental health centers.

Curriculum would include such subjects as mental health administration, planning of mental health services, community organization, consultation techniques, etc. Teaching staff would be derived from community mental health centers, departments of psychiatry, schools of social work, departments of psychology, schools of nursing, community colleges, etc.

In addition, the institute could provide a basis for scientific evaluation of *community* programs, including hospital unit services. This approach would provide for the much-needed exposure of mental health professionals and others to the collaborative nature of community mental health practice.

☐ In the case of the second type of state hospital—that being one which serves a limited geographic area and represents its major mental health resource—there is no danger of duplication of service. Here, it would make sense to maintain the physical and manpower resources of such a hospital, with the following modifications:

- There should be increasing citizen participation in program planning and in the operations of the hospital. The goal might be the eventual turning over of responsibility to a regional mental health board, thus freeing the state from the onus of direct patient care.
- The long-range objective of this type hospital should be conversion into a regional community mental health center. This implies the func-

tional decentralization of many services, the establishment of community and neighborhood outposts, and the close coordination of all services with those provided by other agencies (i.e., welfare, rehabilitation, health facilities, educational facilities, and the court system).

• Implementation of this will lead to significant reduction in the 24-hour census. Usable surplus space should be made available to meet a variety of community needs, e.g., space for general health, welfare, and rehabilitation programs, space for some activities of educational facilities.

More specifically, space can be utilized for regional multiservice and community mental health support centers, for satellite operations of a medical school with emphasis on a family practice residency training program and training of paramedical personnel, for activities of a community college, as an educational and rehabilitation center for children and adults with a variety of handicaps, etc.

Space could also be made available for day and 24-hour programs for the mentally retarded, the aged, etc. However, we should not encourage the relabeling of some facilities for the sole purpose of attracting new Federal money, e.g., making a nursing home out of a state hospital building and, thus, perpetuating the dehumanizing aspects of our present system of care for the elderly, instead of making them beneficiaries of the more enlightened community-based approach.

• If the physical plan of such a hospital is to be maintained, there has to be a proper mix of activities —bringing some traditional community activities into the hospital while taking traditional hospital activities out into the community. Consequently, the hospital staff should be actively involved not only in encouraging the development of various facilities in the community, such as nursing homes, residential care facilities, foster homes, etc., but also in the actual operation through consultation.

Moreover, the hospital should be seen as a potential backup for community efforts, so that community agencies will be less reluctant to assume responsibility for certain types of patients. It is even more important for community agencies to learn that they can call on staff of the hospital for assistance and consultation. Given this mutual respect, the tendency to use each other as a dumping ground for difficult patients will be obviated.

□ The third type of state hospital serves a large geographic area, with paucity or variability of mental health resources. Under such circumstances, a combination of approaches is indicated.

In terms of the area surrounding this hospital, the program outlined for the other two types of hospitals may be launched depending on the richness of available mental health resources. In areas far removed from the hospital, the situation is somewhat different. The objective must be the local development of mental health services where none exist and the strengthening of such services where they are clearly inadequate. In areas that are deprived in terms of the general economy and various social resources, the hospital can play a vital role by physically relocating a small number of its staff.

Such staff can work wonders for a community by • assisting the community in identifying its own untapped resources, outside resources, etc., and in writing initiation and development grant proposals; • providing consultation and education to schools, courts, law enforcement agencies, welfare departments, the clergy; • screening persons considered to be in need of state hospitalization—an essential activity related to the education of physicians, courts, etc., on community mental health; and • operating a crisis intervention and daycare center. The purpose here is to provide a limited amount of direct service, but through involvement of volunteers and paid indigenous personnel, including local physicians and others.

In launching such an effort it is inevitable that, initially at least, the leadership will be with the state hospital personnel. However, there should be a planned effort to turn the leadership role over to the community itself and to permit the community to determine its own needs, priorities, and direction. This should not be confused with a laissez-faire attitude.

It is clear that professional staff, if they become part of the community, will have important input into the decision-making process, but nothing can be more important than the development of strong leadership in the community, particularly mental health boards who are true advocates for the mentally ill and who are not afraid to use their power.

As a particular community gradually evolves, it may get to the point where a comprehensive community mental health center is established. Since the state hospital is located at a considerable distance, transfer to the hospital has many undesirable consequences. Therefore, it is particularly important that the community develop a *full* spectrum of services.

The state hospital, rather than withdrawing its assistance at this point, should expand its community commitment by adding staff to the newly created center. Such staff should have the special task of developing community-based programs for special target groups who, in the absence of such efforts, would have to be transferred to a distant state hospital.

EMPHASIS might be on the development of residential care facilities, sheltered workshops, social rehabilitation centers. If this is done with concerted effort, rurality will not be the problem it now is insofar as attracting qualified leadership manpower is concerned. Educated youth values job satisfaction, action, *and* rurality. Thus, by combining the resources of the state hospital and the community mental health center, one can gradually reach the objective of creating a unified and comprehensive regional mental health system.

However, we will not succeed in establishing such a system until and unless state hospitals are placed under community control. Until such time as real community control can be established, the key to legislative response may be the development of a community-based constituency to challenge the unilateral decision-making power of state governments.

As things now stand, they hamper not only the state hospitals in their efforts to become responsive to the communities they serve but place also arbitrary limitations on the development of community mental health centers. While this is not universally true, a substantial number of community mental health programs face this problem because of exaggerated emphasis on accountability and fiscal control on the part of budget and economy-minded legislators. The existence of community mental health acts is no panacea against this evil; as a matter of fact, the very existence of such acts often provides the trigger for such undesirable developments.

Somehow, legislators and budget analysts have a need for a simple formula by which state funds should be allocated to community mental health centers. However, this formula is not likely to consider such factors as need, economic capability, level of program development, geographic location with relative ease or difficulty in recruiting, differentials in pay necessary to attract personnel, etc.—all of which are generally well known to center boards.

Once the state government has decided to provide subvention payments for community mental health programs, the next step is to maintain control over the staffing level and to allow only for routine salary increments. Thus, the desire of a center to grow in order to meet the unmet needs of an additional target group is ignored and, unless the center can find alternate resources to match a Federal growth grant or an additional staffing grant, it is forced to stay at the status quo. In other words, the autonomy of the community mental health center to determine its own future and rate of development is completely undermined.

The question can, of course, be asked: Why maintain a state hospital at all? There is no longer any argument that the traditional custodial state hospital must be eliminated. But would proponents of the total abolition of the state hospital go so far as to advocate the elimination of the Fort Logan Mental Health Center and similar programs which have been in the forefront of advances in the mental health field? I think not.

As inadequate as state hospital facilities may be in many locations, there is a real danger that we will close them without having provided substitute facilities in the community. Where state hospitals are closing, we should know what is happening to their patients, particularly to those who are chronically disabled and who don't engage in help-seeking behavior. It has been said that patients sent to a state hospital are victims of an *out of sight, out of mind* attitude. While this is generally true as far as their immediate family is concerned, they still remain visible by their sheer numbers.

On the other hand, some patients released into the community without adequate followup are likely to be completely forgotten and will, more than ever, be out of sight, out of mind. One cannot assume that the compassionate warmth of the community will embrace them inasmuch as many of our American communities suffer from a loss of sense of community. Public apathy has permitted the continued existence of veritable hellholes of local county jails, detention facilities, nursing homes, etc. In many places people refuse to vote for bond issues or mill levies to enable their local school systems to stay open. What makes us so confident that our friendly neighbors will treat the mentally ill any better

All this may sound as though I am opposed to a community mental health system of care. Nothing could be further from the truth. I am trying to be realistic about what is happening in this country. Our foremost concern must be with the mentally ill. The shift from institutional care to *adequate community care* must go full speed ahead. But, let us not deprive the sickest among the mentally ill of their last societal support by releasing them from state hospitals before we can be sure they will receive care in the community that is at least as good as what they received at the hospital. ■


IOMAS S. SZASZ, M.D., PSYCHIATRY: A CLEAR AND PRESENT
DANGER

"Involuntary psychiatric interventions of all kinds continue to enjoy widespread popular and professional support."

It seems likely to me—although perhaps opinion surveys would show otherwise—that most Americans still believe that physicians should diagnose and cure disease, and should leave detecting and controlling deviance to others. Of course, there is one group of physicians—the psychiatrists—whose job has always been not to cure disease but to control deviance.

If we were to ask how professionals and laymen have reconciled this inconsistency—that is, their ostensible belief that physicians should treat only the sick and only with their consent, with the actual practices of institutional psychiatrists *treating* people who are not sick and against their will—the answer would be: by attributing *mental illness* to the victims of institutional psychiatry, and by calling all manner of involuntary psychiatric interventions *treatment*.

This fake medical facade of psychiatry is, perhaps, crumbling. At the same time, because of the political and economic power of this profession, and because of the scientific legitimacy which the imagery and rhetoric of *mental illness* and *psychiatric treatment* lends it, involuntary psychiatric interventions of all kinds continue to enjoy widespread popular and professional support.

To weaken this support, which has long been one of my aims, it is necessary that people—especially persons concerned with civil liberties—be more clearly aware of what psychiatrists actually believe and do.

In 1973, Roche Laboratories, a division of Hoffman-La Roche, Inc., conducted an extensive survey of psychiatric opinions on a variety of social issues. They sent questionnaires to *every sixth U.S. psychiatrist concerned with patient care*, and published the results in a series of pamphlets free to psychiatrists.

The results, so far ignored in the popular press, show clearly and convincingly that psychiatrists constitute a clear and present danger to the freedom and dignity of the American people. A few illustrative examples, selected to support this claim but not otherwise distorting the opinions reported, should suffice.

In the survey on *The Changing Patterns of Marriage*, the psychiatrists were asked about marriage counseling, and gave the following answers:

- Do you believe that marriage counseling is . . .
  - ☐ Generally effective 33.9%
  - ☐ Occasionally effective 56.8%
  - ☐ Rarely effective 9.3%
- Do you think that counseling should be mandatory for the couple seeking a divorce?
  - ☐ Yes 43.7%
  - ☐ No 56.3%

Among the *Comments* on this question that the respondents offered were these two: *Mandatory counseling if there are children, not otherwise*; and, *Mandatory counseling in divorce cases can help the couple understand why their relationship didn't work and prevent them from making the same mistake again.*

In the survey on *The Crisis in Education*, the psychiatrists were asked about the psychological evaluation—involuntary, of course—of teachers, and gave the following answers:

Do you believe there should be psychological evaluation of teachers

- As a screening process?
  - ☐ Yes 65.9%
  - ☐ No 34.1%
- As an on-going process?
  - ☐ Yes 55.1%
  - ☐ No 44.9%

On this subject, one psychiatrist offered the comment: *If psychotherapy is presented positively as an asset to teaching, no really concerned teacher could dismiss it as an infringement on his rights.*

In the survey on *The Prisons*, the psychiatrists were asked about vari-

---

One of the most controversial figures in psychiatry today, Dr. Szasz is Professor of Psychiatry, Department of Psychiatry, College of Medicine, State University Hospital of the Upstate Medical Center, Syracuse, N.Y.

ous kinds of sentencing for criminals gave the following answers:

[illegible]	Percentage of respondents [illegible]
• [illegible] sentencing on the [illegible] of the [illegible] of the offense	24
• Sentencing based on a [illegible] of the [illegible] of the offender	21
• Indeterminate sentencing with [illegible] on the [illegible] of the prisoner	59

In the same survey, the psychiatrists were given a choice of three options with respect to controlling criminals, and gave the following responses:

Would you be in favor of	Percentage of respondents checking this answer
• Retaining the present system of [illegible] on the basis of decision [illegible]	[illegible]
• [illegible] therapy for all convicted criminals	50
• Prison sentences for all offenders regardless of a possible mental disorder	19

Finally, in the survey on *Aspects of Psychiatric Hospitalization*, the psychiatrists gave the following response to the questions put to them:

• [illegible] mental hospitals?

☐ Yes	[illegible]
☐ No	[illegible]

• Are you in favor of further practice and research in psychosurgical techniques?

☐ Yes	[illegible]
☐ No	[illegible]

• [illegible] of psychiatric techniques with [illegible] sentencing for prisoners [illegible]?

☐ Yes	[illegible]
☐ No	[illegible]

• [illegible] hospitalization?

☐ Yes	[illegible]
☐ No	[illegible]

Among the relevant and revealing comments on this subject were these:

On psychosurgery: *Anyone who has any experience with chronically disturbed patients knows that they experience anguish as real as any pain known to man. [illegible] considering [illegible] we must consider psychosurgery. [illegible] to incarcerate and restrain or continuously sedate them with medication than to subject them to psychosurgery that is a relatively safe procedure and effective in many cases.*

On the use of psychiatric techniques with indefinite sentencing: *If a psychiatric patient is homicidal or suicidal we act to restrain him or her from self-injury or injuring others not for a given period of time but for as long as is indicated.*

On involuntary hospitalization: *People who wish to abolish commitment are overly concerned about patients' civil rights and insufficiently concerned about their illnesses. Of course there have been abuses in the system of involuntary hospitalization, but the total elimination of this system [illegible] and hazards. [illegible] the problem? I favor a view that sees society's role and responsibility as a protective one. We [illegible] that mentally and emotionally disturbed people are vulnerable people vulnerable to [illegible] and [illegible]. Psychiatric patients need [illegible] protection.*

What do these psychiatric self-disclosures tell us?

They tell us that 41.? percent of the psychiatrists responding support [illegible] counseling—that is, psychiatric intervention imposed by the state—for each and every person who wants to [illegible] his or her marriage. This means that, [illegible] their [illegible] large numbers of psychiatrists would make the granting of [illegible] contingent on the persons [illegible] subjecting themselves to psychiatric [illegible].

Clearly, regardless of the effects of marriage counseling on the clients, such a measure would convert, by the stroke of a legislative pen, millions of men and women seeking divorce into *mental patients*. This sort of drafting of persons into the legions of the lunatics, this dastardly degradation of persons into patients, of men and women into cases—which I have elsewhere called the *manufacture of madness*, and illustrated with the psychiatric conversion of masturbators and homosexuals into mental patients—is perhaps an even greater threat to human freedom and dignity than involuntary mental hospitalization.

I say this because, while in psychiatric incarceration the coercion is overt and therefore evident, in measures such as compulsory marriage counseling, it is covert and hence elusive.

These psychiatric self-disclosures tell us further that from one-half to two-thirds of the psychiatrists responding support the compulsory psychological evaluation of teachers. The powerful psychiatric inclination toward patient-recruiting, on which I remarked above, is manifested in this response also. Indeed, one of the respondents here offers a comment extolling the virtues of coerced psychotherapy for teachers, although he was asked only about their evaluation.

We learn also that 59 percent of the psychiatrists support the indeterminate sentencing of persons convicted of breaking the law—regardless of the offense, and that they would release their prisoners only contingent on rehabilitation. One-half of the respondents support coerced therapy for all convicted criminals.

Here again we witness, on the one hand, a massive psychiatric endorsement of involuntary psychiatric interventions imposed on the persons in the grips of the [illegible]. The psychiatric penchant for [illegible] [illegible] is again [illegible] clear.

Finally, we learn of the psychiatric massive endorsement—ranging from [illegible] percent to [illegible] percent—of compulsory psychiatric treatment [illegible] right to treatment of

neurosurgery on persons with healthy brains called *psychosurgery*; of medical tortures called *enforced psychiatric techniques*; and of psychiatric imprisonment called *involuntary hospitalization*.

Is this not enough evidence to support the claim that psychiatrists pose a clear and present danger to the freedom and dignity of every American? If not, what would be?

As matters now stand, the American people cannot make an informed choice about involuntary psychiatry. They cannot do so, partly, because the facts of psychiatric coercion are, with their own connivance, hidden from them; and partly, because the leading authorities of our society continue to represent adversary psychiatric situations as non-adversary.

"As matters now stand, the American people cannot make an informed choice about involuntary psychiatry."

When a person is *hospitalized* and *treated* against his will, these interventions are *prima facie* evidence of a conflict—between him and those who impose *hospitalization* and treatment on him—and hence of an adversary situation. Nevertheless, the courts, the churches, the colleges, the schools of law and medicine, all articulate this as *psychiatric hospitalization* and *treatment* for *mental illness*.

One of the most dramatic displays of this pro-psychiatrist and anti-patient definition of *social reality* is that in medical schools and psychiatric residency programs students and young physicians are taught only how to commit people. They are not taught—indeed, they cannot be taught—how to free people from commitment.

To see this in perspective all we need to do is imagine how our judicial system would work if courts and churches and law schools would define district attorneys and prison wardens as the allies, rather than the adversaries, of the defendants and prisoners; if, further, law professors could train students only to be prosecutors; if, indeed, teaching students how to be defense attorneys would be incompatible with the position of faculty members in law schools.

I believe that to change this time-honored system of scapegoating the so-called *mental patient*, we must now extend appropriate recognition, in medical and psychiatric education, to the adversary nature of the relationship between the citizen accused of mental illness and his would-be *therapists*.

To be sure, some psychiatrists believe that *mental health* is more important than individual freedom; that *psychiatric treatment* is more important than due process; and that institutional psychiatry is more important than free political institutions. If so, let them say so. Let them make the alternatives and their choices among them clear—so that the American people can weigh the alternatives and make their own choices.

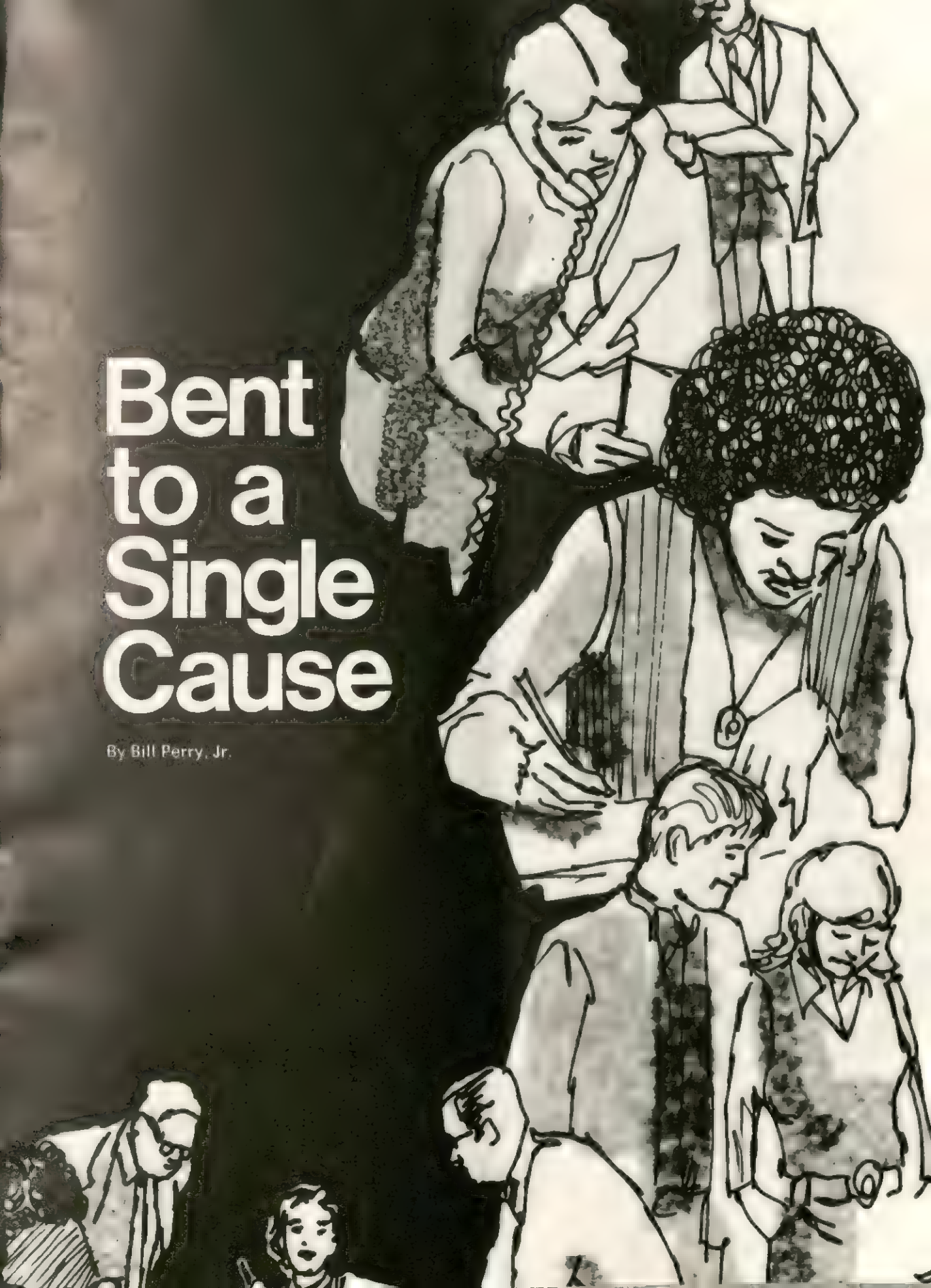
The Bible warns that *A House divided against itself cannot stand.* Barely more than 100 years ago, our house was divided on the question of whether some men and women should be masters, and others slaves. Now it is divided on the question of whether some men and women should be medical masters, and others psychiatric slaves.

But perhaps this dilemma can be put even more precisely. A century ago, the question was: In a nation pledged to the freedom and dignity of the individual, should employers needing workers have a legally sanctioned access to involuntary servants? Now it is: Should doctors needing clients have a legally sanctioned access to involuntary patients?

But it is the other way around, it is the madmen who need the mad-doctors, say the psychiatrists and the true believers in their mythology. Do they really? Or are we again deceiving ourselves with a self-flattering fable, having transferred the burden from the white man to the man in the white coat? ■

Bent to a Single Cause

By Bill Perry, Jr.



Only their numbers
suggest a group.

Their deeds say
individuals
bent to a single cause.

They form a phalanx
for change, these
many men and women:

From city and town;
from Chapter and Division;
from earth and moon.

Find them in the courts
or Congress.
Find them in the streets
or hospitals.
Find them in the right
when wrong prevails.

Who are they,
those changers of
status quo?

They are volunteers all
bent to a single cause.

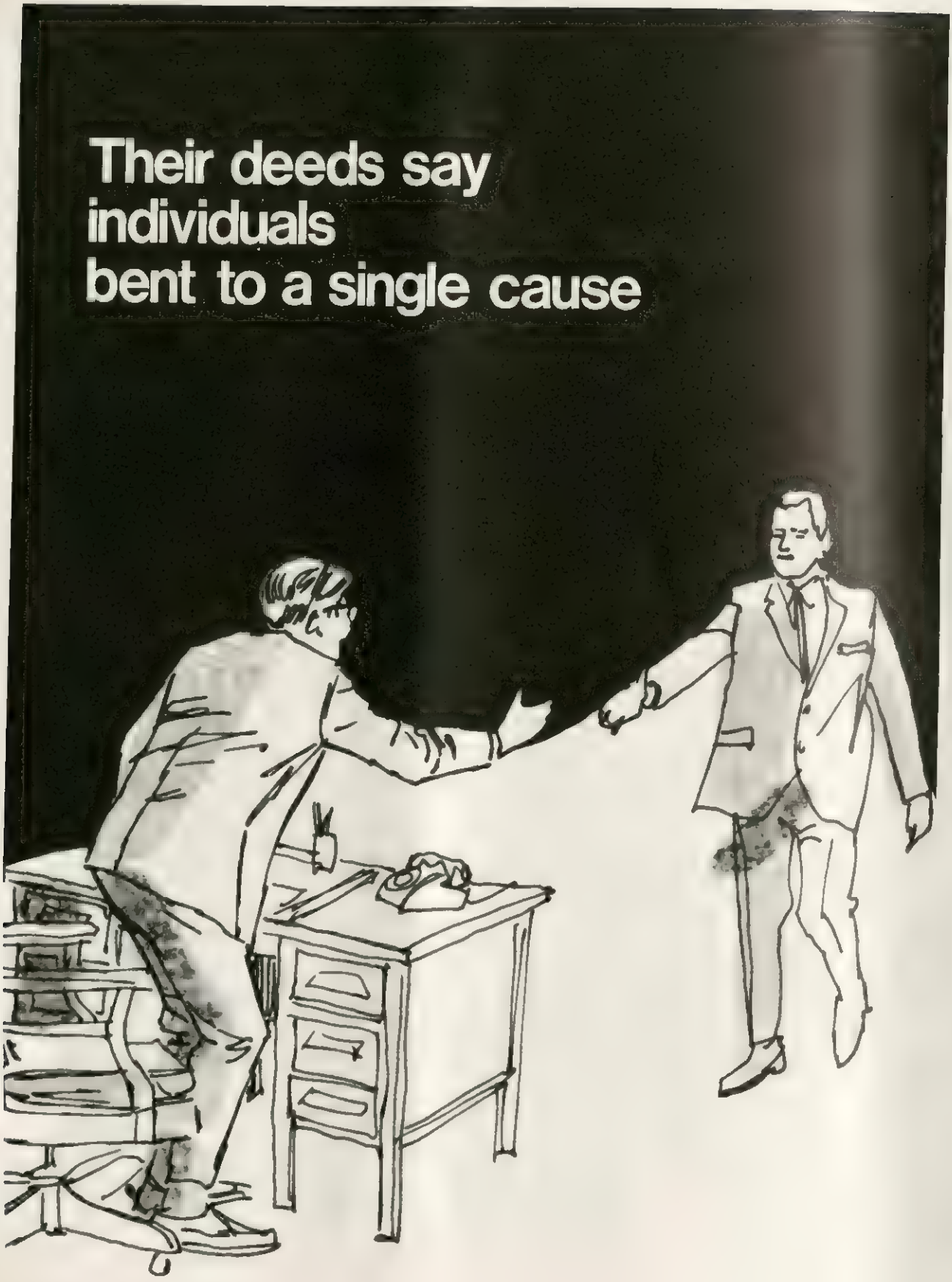
Make a difference,
they say.
Make it better, they do.

They change the
minds of men
to better the mind of man.

Only their numbers
suggest a group.

Their deeds say
individuals
bent to a single cause.

B. P.


Their deeds say
individuals
bent to a single cause

TURNING A PROBLEM INSIDE OUT

By Eric W. Fine, M.D., D.P.M. and
Pascal Scoles, M.S.W., A.C.S.W.

THERE is little doubt that alcoholism is a major public health problem. One only has to look at the many areas in which the general population is affected by it—highway safety, family life, crime, industry, mental health, just to name a few. Needless to say, the implications for the community, as well as for the alcoholic himself, are far-reaching. Not only is an individual's personal life and self-image adversely affected by alcoholism, but so is his economic and public life. For that reason, the problem needs to be viewed as both an individual and community one.

With this in mind, it would appear that a community treatment program for alcoholism is appropriate for a number of reasons, ranging from the sociological to the medical to the logistical. For instance, when the health facility is located close to the community, it can be more knowledgeable of and take better advantage of all the resources of the community, i.e., the welfare department, social agencies, schools, etc. In this way, all resources can be mobilized at one focal point for the prevention, detection, and rehabilitation of alcoholism at all levels. Moreover, the problem of distribution of services can be minimized, and continuity of care throughout treatment provided from the first detection phases to rehabilitation.

In terms of transportation, treatment centers closer to the community are clearly more accessible than one centralized facility serving an extensive catchment area. Treatment at the community level also eliminates the apprehension, humiliation, and loss of identification with the patient's family and friends, which a patient often experiences in a large institution far removed from his home and community, and ensures minimal dislocation.

Dr. Fine is Director of the Alcoholism Program, West Philadelphia Community Mental Health Consortium, and Associate in Psychiatry, University of Pennsylvania School of Medicine.
Mr. Scoles is Assistant Professor of Mental Health, Community College of Philadelphia.

Tying together these sociological, medical, and logistical aspects is a further, and perhaps the most compelling, argument for the treatment of alcoholism on the community level. Simply stated, it's this: The environment in which the patient dwells is invariably associated with the development and perpetuation of his alcoholism. Consequently, his treatment in an environment removed from the community geographically and philosophically may not be as effective as dealing with him in the setting in which he must cope daily. In other words, if an individual's excessive drinking emanates from social and psychological pressures he has experienced in the community, as much available data indicates, it stands to reason that the most effective treatment would be in the context of the problem, that is, in his own community.

Thomas F. A. Plaut outlines six characteristics for the adequate community services for problem drinkers:

- A wide range of services should be provided.
- The facility should be able to meet the demands on it.
- It should be staffed with skilled personnel.
- Treatment facilities should include both medical and behavioral aspects.
- The center should serve a wide range of problem drinkers.
- The center should be coordinated with other agencies (welfare, public health, etc.).

Given these considerations, it would seem that the community mental health center is the ideal foundation on which to build programs for the treatment of alcoholism. One such example of this is the West Philadelphia Community Mental Health Consortium.

Under terms of Federal and state CMHC legislation, the Consortium began operation on July 1, 1967, as the collaborative effort of six hospitals and the University of Pennsylvania. It is now governed by a Board of Directors that is composed of 11 representatives of the member agencies and 11 community representatives selected by the citizens of the area served.

Known technically as Catchment Area 3, the Consortium's service area covers 21 square miles, or slightly more than half of West Philadelphia, and has a population of just over 200,000. The northern third of the area contains all of its hospitals and approximately 60 percent of its population. Racially, the area is close to 50-50 white and black, with the latter group increasing. The white segment contains appreciable numbers of people of Irish and Italian extraction.

In order to qualify for funding from the Federal Government, any alcoholism program must be organized on a comprehensive basis, and the required services must include detoxification, inpatient, outpatient, intermediate care, emergency, consultation, and education services. Of course, different communities will require different models of program structure to allow for effective delivery of service, and the design of any program must take into consideration the geography of the catchment area, the economic and educational characteristics of the population, and the existing services for treatment of physical and psychiatric illness generally, and alcoholism in particular.

The alcoholism program of the West Philadelphia Community Mental Health Consortium was developed in January 1971 on the basis of these factors along with a maximum of community participation, which helped to identify areas of alcohol abuse that responsible community groups felt were of concern.

An interdisciplinary approach was instituted, community resources such as the National Council on Alcoholism, family services, bureau of vocational rehabilitation, Alcoholics Anonymous, schools, clergy and police were involved, and emphasis was placed on a community-based, outpatient approach to the problem. Further, the organization of the Consortium was such that the alcoholism program could take advantage of several already established and integrated mental health

services, in addition to a close relationship with the Department of Community Medicine, and the Department of Psychiatry of the University of Pennsylvania.

The outpatient services were decentralized, to allow for as close a participation as possible between therapists and the community they were serving, both geographically and emotionally. In each of the seven existing counseling centers, located in strategic areas in the catchment area, an alcoholism counselor under professional supervision is responsible for the continuing care of a caseload of alcoholics and their families.

The counselors are selected from applicants with some basic training in mental health, who are motivated to relate to persons with alcoholism and who are familiar with the community and its needs. Before they are given any responsibility for patients, they receive a short orientation program to familiarize them with the organization of the Consortium, and some basic reading on alcoholism is suggested. In-service training then continues as they relate with alcoholics under supervision. They participate, as co-therapists with a professional, in group psychotherapy as well as individual counseling.

An important part of their work is in the area of *outreach* activities which involves their spending a proportion of their time in the community. They are encouraged to establish contact with community groups interested in alcoholism as well as becoming directly involved with the families of patients through home visiting. Maintaining as close contact as possible with patients and community is continuously reinforced during in-service training.

To ensure continuity of care and efficient patient *flow* from one service to another, the catchment area has been divided into three areas for administrative purposes. Each area consists of at least two counseling centers and associated inpatient facilities. One of the areas includes the 10-bed inpatient unit organized for the treatment of alcoholics.

These beds are part of a psychiatric unit in a general hospital and are serviced by a psychiatrist, social worker, psychiatric nurse, an occupational therapist and two nursing aides. This allows for intensive evaluation and therapy during the patient's stay in the hospital, which is usually four to six weeks.

While in the hospital, the patient is introduced to and visited by the counselor who will be responsible for his support in the community after discharge. The services provided in the hospital milieu include group and individual therapy, social evaluation, rehabilitation counseling, and drug therapy (including Antabuse) where indicated.

The 24-hour emergency service developed by the Consortium at Philadelphia General Hospital has been adapted to deal with the special problems presented by the alcoholic. Sources of referral to the various elements of the alcoholism program are made very clear to the staff. A physical examination is made by an intern or resident on admission to exclude any serious organic disorder and this is followed by evaluation by a psychiatrist and counselor when referral is made.

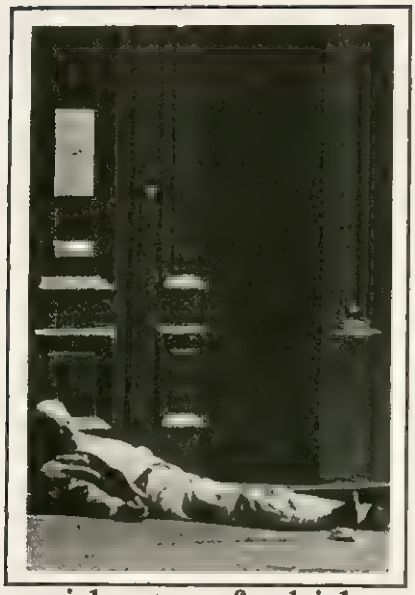
If detoxification is necessary on an inpatient basis, this is carried out either at the general hospital or in the alcoholism inpatient unit, depending on the physical condition of the patient. In either case, the patient is registered in the alcoholism program, and close contact is again maintained with him, in an effort to ensure his receiving ongoing treatment following hospitalization. It should again be emphasized that merely giving patients with alcoholism, appointments for therapy sessions has been shown to be quite inadequate and, in many cases, a much more personalized referral system is necessary. The probability of increasing the patient's motivation in this way has already done much to improve attitudes towards the alcoholic in the hospital and in the community.

To complement these services, an intermediate care facility is being developed that will provide a more protected type of care for a number of patients during their transition from hospital to community living. It will be a residential facility for 12-15 patients with no rigid time limits as to length of stay. This will depend on each individual's needs. If, after a period of assessment, a patient appears too deteriorated to function independently, but does not require institutional care, he will be considered for placement in a special boarding home where he will continue to receive support and care on a regular basis. This should allow all but the most severely deteriorated alcoholics to continue to participate in community activities without the undesirable and more expensive alternative of institutional living.

No program of this kind would be complete without providing an active consultation and education service. This serves not only to provide essential information about alcoholism, but mobilizes forces in the community that might be effective in changing attitudes about alcohol abuse. In this area particularly, a close working relationship with the local office of the National Council on Alcoholism is of extreme importance.

The planning of an alcoholism program that is closely integrated with a community mental health center demands a careful consideration of existing services, so that the *dovetailing* of the alcoholism program with these services can proceed smoothly. Both the organizational difficulties, as well as staff and community attitudes towards alcoholism, must be taken into consideration and related to at an early stage of development.

In this respect, one should be aware of the rejecting and moralistic attitudes that still exist towards alcoholism by large segments of the community and, unfortunately, by too many professionals. This can be modified by obtaining solid community support for the alcoholism treatment facility, and by involving professionals from all disciplines in a viable program with realistic treatment goals. ■



Almost every American city with a population of over 500,000 has a skid row neighborhood. This area is easily identifiable by the concentration of dilapidated hotels, flophouses, taverns, pawnshops, missions, and cheap restaurants, and by the blatant poverty and degradation of its inhabitants. While it's true that a large percentage of such people are addicted drinkers, the majority (65 percent) are not. Like their alcoholic neighbors, these nonalcoholic residents of skid row are destitute, homeless, and in poor health. They include permanent residents, with some source of income from part-time employment, public assistance or government pensions, and transients who often drink with the alcoholics but who are not part of the alcoholics' groups.

ONE VICIOUS CIRCLE

In sum, skid row inhabitants come from every social strata, ethnic group and educational background. With all of this in mind, let's examine why an alcoholic would be attracted to such blighted areas or willing to accept skid row as a way of life.

By Joel Freedman, M.S.W., A.C.S.W.

Mr. Freedman is a Social Worker at the Veterans Administration Hospital, Canandaigua, N.Y.

One reason is that he frequently cannot live elsewhere. Food on skid row is grimy but inexpensive; flophouse rooms may not be fit for human habitation but rent for less than a dollar a night; available resources exist, notably the Salvation Army, that help to meet some of his basic physical needs; and it's acceptable to solicit money by begging—a practice not tolerated elsewhere. In fact, one transient alcoholic patient told me that he had been able to exist on skid row on a monthly pension of about $80.

Even when the alcoholic makes the choice to leave skid row, he is usually handicapped by his poor health, slovenly appearance, insufficient funds, and the lack of employment opportunities available to him.

Secondly, since society tends to look down upon its alcoholics, a man may use skid row to conceal his drinking problem from family and friends. On skid row there is no need for the alcoholic to make rationalizations or for him to suffer from feelings of shame. He no longer feels pressures to adhere to the norms and values of the larger community and he may drink without fear of ostracism and rejection.

Perhaps the biggest attraction of skid row is its unique subculture, which offers several advantages to the alcoholics on its streets. The skid row way of life is, indeed, a subculture vis-a-vis its status order, its norms and tabus, its prescribed ways of behaving toward members and non-members, and its provisions for mutual aid and human companionship.

Contrary to the popular conception of the skid row alcoholic as a social isolate, most skid rowers belong to groups that provide mutual assistance in meeting the problems of physical survival and *emotional support found in the acceptance by, and the companionship of, fellow human beings.*

The vast majority of alcoholics on skid row belong to one of two groups—*lushes* or *winos.* Lushes are the prestige group of alcoholics who drink whiskey, are in better physical and mental health than winos, and are the most likely to ever readjust to the norms of the larger community. Winos, on the other hand, are those individuals who habitually drink wine and are characterized by a run-down appearance, fetid odor, and a tendency toward unpredictable behavior.

Largely out of rejection by the lush group, winos tend to group together. Unlike the strong group cohesion often noted among lushes, wino groups are frequently of short duration, governed by the price of a bottle, the time it takes to raise enough money for its purchase, and the time spent drinking the wine.

Only a minority of skid row alcoholics are *isolates.* These individuals —referred to as *characters* or *rubby dubs* by the other groups—habitually drink non-beverage alcohol, are self-destructive, and often psychotic. Such persons are few in number and are avoided by the other alcoholics.

When the alcoholic first arrives on skid row, he usually has been socially and geographically mobile for some time. Generally, he joins an already existing group for whom he buys some alcohol and may remain within that group as long as he conforms to its standards.

Several tabus are placed on the member. He must never interfere when another member is soliciting money, food, or alcohol from an outsider. Such butting in is known as *breaking into a pitch*, while the outsider or tourist is referred to as *a live one.* Having begged enough to procure a bottle, the member is expected to return and share it with the group. The other members, in turn, must share the financing of the bottle, which is then passed from mouth to mouth.

Each member is also required to exploit the various neighborhood missions without becoming overly dependent upon them or taking to heart the message of reformers. Appearance and decorum must meet minimal standards, but a member cannot become too dirty and untidy, lest he *turn off live ones* and call police attention to the group. Significantly, it is tabu to discuss one's personal problems, although this restriction may be relaxed somewhat, if the member has contributed the major share toward the bottle's purchase.

These groups serve a number of purposes that are gratifying to its members. As long as each member takes his turn working and begging a steady supply of alcohol is assured. The group knows how to work the grapevine when the police are in the vicinity, thus enabling its members to hide. Should a member be seriously ill, the group permits him to be detected so that he can receive proper medical care.

gh its unquestioning acceptance of each member and through its methods of making only those demands that a member is willing e to meet, the group is able its members' psychological

despite the hunger, cold, shelter, and ill health associated with the life style of the skid row alcoholic, many such persons one reason or another—re- on skid row or, if they do ultimately find their way back.

Effective rehabilitation prospects have not been very successful. While substituting hospital care for prison confinement is appropriate from a humane standpoint, *revolving door* hospitals can only permit the skid row alcoholic to *dry out*, be treated for the acute effects of intoxication and related physical ptoms, and return to his old habitat.

There has been no evidence that long-term care in psychiatric facilities has positive results other than those related to some of the same protective functions of the jails. Psychologically oriented alcohol rehabilitation programs exclude skid rowers because of their unwillingness to consider abstinence or to change their life styles. Functioning essentially as a form of group psychotherapy, Alcoholics Anonymous has programs in nearly every city in America, but this organization has had little, if any, effect on the living condition of skid rowers.

It has been my experience that placing skid row alcoholics in community care homes is rarely a successful venture, unless rigid supervisory control of activities and funds is made possible. Before such controls can be effected, it is necessary to initiate incompetency and sometimes commitment procedures and these usually cannot be undertaken until the alcoholic has suffered such extensive brain damage that he is totally unable, even when sober, to sustain any form of independent living arrangement.

Another focus of attack on the problem revolves around the efforts of community action programs designed to eliminate skid rows. One authority asserts that *after a long and rich history in which literally millions of persons have come and gone, skid row now appears to be fading from the American scene.* However, the passing of skid row has been correlated with the dispersion, not the absolute decline, of its population. According to welfare commissioners in 40 American cities, the effects of changing welfare policies and urban renewal programs have not decreased homelessness but have merely induced skid row populations to be more mobile.

The skid row alcoholic has virtually nothing in his favor. He is physiologically and psychologically addicted to the point that he lives only to drink. The dyssocial subculture of the skid row environment results in the persistence of behavioral patterns contrary to the norms of the larger society. Associated problems of poverty, physical and mental illness, lack of vocational skills and societal abandonment only intensify the desperate situation of the skid row alcoholic and create a vicious circle that is nearly impossible to break. He is an embodiment of society's unresolved problems, and usually is considered to be beyond hope and rehabilitation.

A multi-functional focus of attack on skid row alcoholism requires the involvement of professional planners, mental health and alcoholics' associations, social welfare agencies at all levels of government, community action groups, psychiatric and health facilities, the courts and law enforcement agencies, as well as other decision-making elements in the community. There is a tremendous need for more action research, new experiments in relocating skid row men and establishing various types of half way houses, and for the development of new casework and rehabilitation methods and programs to serve the skid row alcoholic. ■

Survival in the arena of human services demands that today's program planner follow a

Pattern for Change

By Ralph G. Hirschowitz, M.B., Ch.B.

Most urban environments are over-populated—by human services, as well as citizens. These agencies often operate in isolation from one another, exhibiting a posture that is more often competitive than collaborative. Such competition has given rise to a fragmented state of affairs wherein populations that are deprived rarely receive needed services in a way that permits the comprehensive or continuous resolution of their problems.

Dr. Hirschowitz is Assistant Professor of Psychiatry, the Laboratory of Community Psychiatry, Harvard Medical School, and Director, Office of Prevention, Massachusetts Department of Mental Health.

For instance, there are many gaps at those critical points where the output of one agency should become the input of another. Referral routes to and between agencies are unclear. Often, overlap or redundancy in some human service areas co-exist with a paucity of necessary services in other areas. Clear definitions of purpose, boundary, triage or priority are only rarely elicited. There is incoherence, confusion within and between systems, and minimal public program accountability. Consumers exercise little influence over policy, are often misdirected, and lack primary gateways for precise routing to needed human services.

This topsy-turvy proliferation did not just happen. Rather, it stems from values and assumptions fundamental to the American tradition. In the *achieving society*, enterprises compete with one another on an industrial model which assumes that more effective enterprises thrive and grow, while less effective ones become obsolete and disappear.

Such regulation has been effective for industrial enterprises with free and open marketplaces in which consumers put comparable products to the test, but the same cannot be said in the area of human services. For *professionalism* has erected screens of *confidentiality* against consumer accountability, and guild claims to credentialism and quality control have sometimes served to protect obsolescence. In short, the protective cloak of peer review has pre-empted quality control by the providers rather than the users of services.

True, some pressure for change has come from within professional ranks; however, its impetus stems mainly from the marketplace—the pressures of consumers and consumer advocates. For example, there is a rising tide of consumer participation in policy setting and resource control, with some consumer participatory demands originating at the Federal level.

Even as Federal agencies have mounted carrot-and-stick pressures to promote the supraordinate integration of human service programs, the spirit of such mandates has been subverted by many powerful and politically sophisticated agents. Grant-hunting agencies with easy access to the corridors of Federal power have been able to secure large grants for programs in which, as grantee agencies, they exercised disproportionately large shares of control. Once funded, the *community* components of service programs have often been token additions to traditional clinical *test and treat* operations, thus leaving the promise of many community mental health programs unfulfilled.

In the scramble for these funds, fragmentation, overlap, and discontinuity have been perpetuated within, and by, the labyrinthine Federal structure—one that replicates the patterns of agency isolation, incoherence, and competition visible at local levels.

On top of all this, a further dilemma emerges: the thrust toward centralization and supraordinate control co-exists with a simultaneous thrust towards decentralization, regionalization, and local control. While guidelines are issued from Washington to ensure uniformity, there is, simultaneously, active encouragement of innovative experimental approaches to human services program delivery.

The human services leader finds himself attempting to develop program plans in a context of bewildering complexity. He operates in a pluralistic universe where constituencies and agencies will generate demands that are often contradictory and perplexing. It is imperative, therefore, that this community field be mapped before strategies are elaborated.

To assure his survival while moving towards effective change promotion, the leader should vigilantly monitor two community arenas.

The larger of the two is the *community*, actualized through its citizen groups, vested interest groups, media, influentials, and activists. He needs to scan this inter-group field of community forces—and the loci of power, influence and leverage within it—in search of constituencies. Simultaneously, he should map out his second arena—the public, private, and voluntary organizations responsible for delivery of human services. Here, the leader needs precise information about the most powerful agencies, their governing boards, their constituencies, histo[illegible] traditions, policy-making patterns and ideologies. Such information will make it possible for him to enlist an agency change constituency rather than be excluded, is[illegible] or neutralized.

Thus, the early activities o[illegible] program-planning leader have an infiltrative quality. But he should not take decisive action until [illegible] information base is adequate enough to convert environmental uncertainty into calculable risk, nor should he probe to the extent that further access will be denied him. His immediate goal is survival. When he knows he will survive, he extends his time horizons and begins to establish the *necessary* conditions to thrive.

As he moves into the complex field of community forces, he must pace himself, guarding particularly against the attempt to accomplish too much, too fast, too soon. Where communities are relatively stable and agencies' investment in equilibrium-maintenance is high, he must expect to endure months of political maneuvering with resistance to inter-agency programmatic problem-solving.

During these times, the planner should have many conceptual models at his command. From these he can select those that best fit the task as well as his own personal style.

The planner's problem-solving instruments, thus, should help him to define the inter-system and inter-

group processes within a territory. Models derived from open systems theory can be eminently helpful for purposes of definition, analysis and strategic planning. Open systems models can permit relevant questions to be asked, plans to be simulated and eventual strategies to be formulated. At the same time, the planner must guard against the assumption that vying agencies within a territory actually operate on a *rational* systems model.

Groups, like individuals, pursue their perceived self-interest. Consequently, the mental health leader's focus should be upon change in the group's *perception* of its best interests. The perceived self-interest of a group may be based upon inadequate knowledge or false appraisal of changing realities. In such cases, the provision of information — for instance, about sociotechnical advances or new consumer patterns — can function as a spur to change.

Change motivations within agencies are complex and often paradoxical. Change may occur when it *must*, because survival is at stake. It may also occur in planned, [illegible]ated anticipation of such a necessity, because it is perceived as *needful*. Even in creative, innovative *growth organizations*, change takes place, simply because these organizations want, but do not need, to. Thus, agency practice changes in response to a complex blend of coercive, calculative, and innovative motivational ingredients.

Agencies are disposed to cooperate when they are persuaded that they stand to gain more than they will lose by such collaboration. In attempting, therefore, to facilitate collaboration, there is a substantial burden of proof upon the convening authority and its leader-representatives to demonstrate such cooperation can *multiply* rewards for each and every agency that is participating.

Since the visions of the planner or leader can only be translated into action by existing agencies, he must somehow effect a reconciliation between his own ideal type notions of the way things ought to be and what is acceptable or feasible.

He is least likely to succeed if he attempts to effect change by actively vending his own cherished *prescription* for change. Instead, he should recruit constituents who collaboratively develop a shared vision of what ought to be, and this constituency should encompass both agencies and participating citizens.

It should also include agency policymakers and the professionals who ultimately would have to actualize new programs. For decision makers are more likely to invest themselves and their constituents in programs that they actively develop.

Moreover, the leader should not, alone, accept responsibility for the design or content of new programs. His role behavior is that of the group leader, facilitator, technical resource person, and consultant.

And lastly, he should be seen to be responsive to the interests of *all* members of the community. Any advocacy role should be for, and on behalf, of the total *community*. He is at grave peril of failure if he uses the community as a laboratory for the pursuit of his own dreams.

In some situations the change agent may temporarily have to sacrifice his own [illegible] programs in order to successfully negotiate the *rites de passage* of community [illegible]. By compromising on apparent quality, he can secure a community base of acceptance within the [illegible]. From this base more radical programmatic innovations [illegible].

The novice leader [illegible] the heat of [illegible] crises. He [illegible] time in his professional [illegible] he is still [illegible] in shifting from the [illegible] to that of leader, planner and program developer. As he copes with this role transition and the tensions

of community problem solving, the planner must guard against some occupational hazards.

These perils include the *anthropomorphization of community*. An exclusive early training and focus upon individual patients sets the cognitive stage for concretizing the community as though it were a person seeking treatment. The community is thought of as *sick* and a rhetoric of the *community as patient* may emerge. This model is at best a questionable metaphor, and the pragmatic consequences of its application can be regrettable. Doctoring the community makes the implicit assumption that the planner can *diagnose* the community; furthermore, following the omnipotent, prescriptive medical model, he can prescribe and operate, surgeon-wise, upon the community. Such a posture, while acceptable to patients in the context of hospital wards, is rarely accepted in community contexts.

A related posture stems from the professional's adoption of what S. M. Miller has called the *stupidity argument*. When the professional finds that his prescription for a community is ignored, he may respond by deciding that the community or its representatives are *stupid*. He then adopts the elitist posture of educating the community, ignoring the reality that community representatives are rarely stupid.

As city planners, public administrators and community doctors move from graduate schools into these chaotic urban arenas, they will often prescribe immaculately *rational* solutions to human services delivery problems. All too often, however, such blueprints do not translate into action and change efforts are vitiated. The rational planner's moment of truth arrives when he discovers that change is engagement in a political change *process*, and not achieved by technocratic prescription. ■

Boston's Brookside Park Family Life Center delivers mental health services at the neighborhood level

By Steven S. Sharfstein, M.D. and Farrokh Khajavi, M.D.

The mental health staffing of the center has sufficient depth to provide direct treatment services

IT can be as easy as going to the corner grocery for a loaf of bread or leaning across the backyard fence to talk with your neighbor. The *it* in this case is a unique program in Boston that delivers mental health services at the neighborhood level.

The program is the Family Life Center, established by the Boston Model Cities Administration. There are two such centers in the city, but we'll focus on only one of them as typical of the way in which this particular delivery system operates.

The center is the Brookside Park Family Life Center, located in Jamaica Plain and in the heart of Area I of the Boston Model Cities Neighborhood. It serves a community of 10,000 residents, mostly white, Catholic, and working class.

Designed to provide comprehensive health and social services on a local and easily accessible basis to these families, Brookside Park offers, in addition to mental health services, medical, pediatric and obstetric-gynecological services, assistance with housing and unemployment, and speech and hearing services.

The total staff of the center works within two teams or components—one, medical; the other, mental health. Consisting of paraprofessionals (information and evaluation (I&E) workers and family health workers), physicians and nurses, these teams coordinate the various services provided for any specific family. To further community participation and feedback, the family life center also employs neighborhood residents in administrative and service functions.

The core mental health team consists of a senior psychiatrist (director of the team), a junior psychiatrist (a second-year resident), two psychiatric nurses, and a psychiatric social worker. Some services are provided by a child psychiatrist, a child psychologist and a family psychiatrist. With this in mind, let's examine the major objectives of this component and how these different individuals fit into the overall scheme of things.

IN-SERVICE TRAINING. One psychiatric nurse is assigned to each team at the family life center to provide informal consultation to the other workers. Both on an individual and group basis, these nurses are responsible for an intensive program of in-service training. Many cases that have mental distress as one problem among others can be handled well by other workers consulting with the nurses at regular team meetings, but others require close supervision.

Other link-ups include the psychiatric social worker meeting regularly with the I&E workers who deal with many problems analogous to social case work, the psychiatric nurses working closely with family health workers and medical nurses, and psychiatrists consulting on a regular individual basis with other physicians in the center, i.e., the child psychiatrist with the pediatrician and the adult psychiatrist with the internist.

NEIGHBORHOOD CONSULTATION. Each member of the mental health team spends some time consulting with neighborhood agencies and workers outside of the family life center. This community work has helped the mental health team understand the problems of the people of the neighborhood—unemployment, unwanted children, fear of outsiders, alcoholism and child abuse, and truancy from school. Further, mental health workers have built bridges among neighborhood agencies. Multi-problem families who come to the attention of many agencies receive more coordinated services.

DIRECT TREATMENT SERVICES. Often mental health services in a neighborhood setting consist solely of consultation, referral, and sometimes in-service training. This is dictated by the shortage of mental health professionals. Under such circumstances direct treatment by the professionals remains the function of the back-up mental health center or of the private practitioner. Poor people have become most sensitive to such arrangements. They are demanding more direct services by those who possess the skills.

The mental health staffing just mentioned has sufficient depth to provide direct treatment. This approach has helped a great deal to give the team and its mental health activities legitimacy within the family life center as well as the community. Further, this arrangement has diminished the load on the staff of the back-up mental health center who were once fearful that early casefinding in neighborhoods would

Dr. Steven S. Sharfstein is Chief Resident, Massachusetts Mental Health Center, Boston, Mass.

Dr. Farrokh Khajavi is Lecturer on Psychiatry, Department of Psychiatry, Harvard Medical School, Boston, Mass.

With such centers as this, psychiatrists have the opportunity to get directly into community practice

lead to an unmanageable workload. Direct treatment services consist of • individual supportive and insight-oriented psychotherapy; • the use of medication; • aftercare for patients discharged from the back-up facility; • child therapy and therapeutic tutoring; • group therapy, especially in the nursing homes; and • family therapy, either at the center or in the homes.

The community mental health program of the Massachusetts Mental Health Center—the back-up mental hospital—provides the mental health services for the Jamaica Plain Family Life Center. Following the original negotiations between the Boston Model Cities Administration and the staff of the mental hospital, an agreement was made under which this institution, through an NIMH staffing grant and its residency training program, has provided the necessary staffing for the center's mental health team. The Model Cities program also provides some staffing and program budgeting for this component.

The mental hospital is a university-affiliated community mental health center that has responsibility for a geographic catchment area. The relationship of the neighborhood multi-service center to the back-up hospital is a close one. The mental health professionals have appointments at both the family life center and the mental hospital. This enables the staff to coordinate back-up diagnostic and treatment services in order to provide for continuity of care. The hospital provides not only specialty services unavailable at the center, but also admissions for neighborhood residents to either a day-hospital or a full-time program.

One effect of providing easily accessible mental health services is the reduction of community resistance to consulting mental health workers. When services were first offered, people would not come directly to a psychiatric professional for fear of being judged *crazy*. Traditionally, psychiatric care for the working class has been provided exclusively by large custodial state hospitals. Thus, psychiatrists and their staff are regarded as administering to only the frankly insane. The work of the mental health team directly in the home of residents and their churches and schools has been an effort to undo these old stereotypes.

Further, the junior psychiatrist has worked actively with the community advisory committee of the family life center. He has consulted with them on all major aspects of the mental health program and discussed overall center function with community people desirous of becoming informed in center planning. This role is important in the development of a trusting relationship with the community.

Adolph Meyer, writing at the turn of the century, suggested that psychiatric work should be focused in neighborhoods and that psychiatrists work closely with other medical practitioners in the area. The history of psychiatry in this century has been a movement to bring services closer to where people live and work.

The Community Mental Health Centers Act in 1963 brought to fruition this trend. The development of neighborhood health and multi-service centers such as Brookside Park now provides the opportunity for psychiatrists and other mental health personnel to get directly into community practice.

Yet, the necessity of evaluating the effectiveness of mental health services in the neighborhood is quite obvious. There is no doubt that easy access of community residents and agencies to mental health workers will lead to early case finding and possible early intervention. Although this may be expected to lead to the prevention of serious mental disorders, no hard data exists as yet. Whether neighborhood services will lead to a decrease in the number of patients from the neighborhood seen at the community mental health center is another speculation that needs scrutiny. It has been demonstrated elsewhere that along with the establishment of neighborhood health centers, there has been a decrease in the number of pediatric emergencies seen at its back-up hospitals; but psychiatric services may be very different and that early detection may lead to an increased caseload that must be taken up by the back-up institutions.

Moreover, how does one measure the increased effectiveness of other community resources—e.g., physicians, lawyers, priests, welfare workers—in dealing with the mental health issues as part of their work? Mental health consultation is one of the primary tools of community psychiatry, but the actual impact of a network of consultations and community intervention on a neighborhood level has yet to be measured. Certainly, the family life center as a model for providing mental health services offers many opportunities for such research. ■

BOOKS

Birthrights
Richard Farson
New York: Macmillan Publishing Company, Inc., 1974. 227 pp.

Dr. Farson has set forth in this book a series of ways in which children might live under the same rules as we do and proposes a very radical approach to the concept of childhood. Reviewing the older concepts of a non-childhood and now supported by what he describes as the *politics of childhood*, Farson suggests overturning—often in a very dramatic way—many of the institutions that underpin the relations between adults and children.

Beginning with concepts about alternative home environments, he suggests that our ideas of child care in this country came out of a process of people who *needed each other* and, therefore, often *came to love each other*. Now he feels that the opposite is true: *we need each other because we have come to love each other*. His own data about the brutality that adults inflict on children does not quite support this point.

However, Farson does suggest that there are different ways that children could live, either in groups or by exchange within families. From there, he goes on to discuss how homes are not designed for children, and how architectural and other changes might be made. In some ways, this is the easiest of his concepts to see in fruition. His proposition gets more difficult when he tackles the area of *right of information* and suggests, for example, that *no records should be kept other than those the child wishes to keep*. Here, he begins to buck the tide of the overall behavior of society. His crusade proceeds in discussing the right to freedom from physical punishment to the right to sexual freedom and eventually to the right of economic and political power for the child.

This is a much bolder extension of earlier works, such as those of Paul Adams, that have pointed a way towards freeing up children from some of our adult shackles. Unfortunately, the final chapter called *Redesigning the American Way of Life* seems to lack an expression of the tools needed to carry out this redesign. It is true, as he points out, that we conspire to keep children *weak, innocent, helpless, and dependent*. But in his calling for a total revolution of our society, Farson is asking for something that not only will be opposed but for which we may lack the capacity.

It would seem, therefore, that the book's worth lies more in its radical quality and description of what needs to be done for children rather than offering methodology, pathways, and realistic approaches to changing the problems. His version of the child of the past and the child of the present seems fairly correct, although he tends to editorialize rather loosely with some facts. His projection of the child of the future and the state of that child's relationship to adults calls for more imagination than most of us have. If, however, one wishes to be disturbed and stimulated at the same time, it would be well to read this book.

HENRY H. WORK, M.D.
Director, Professional Affairs
American Psychiatric Association
Washington, D.C. 20009

Medical Student: Doctor in the Making
James A. Knight, M.D.
New York: Appleton-Century-Crofts, 1973. 244 pp., $12.95 (Hardbound), $7.95 (Softbound).

Although the medical student *experience* is a popular subject in conversation among graduate and student physicians, physician-authors have been rather timorous in their treatment of it. While much of the lay literature has been audacious in its exploration and exploitation of the medical mystique, much of the professional literature about medical students has focused upon biographical, demographical, and achievement data. *Medical Student: Doctor in the Making* is a sensitive, sensible analysis of a critical stage in the life of a physician and, as such, begins to fill a significant void.

Dr. Knight brings unusual talents to the preparation of this book. A careful reading is in itself a cultural experience, as the author thoughtfully selects from

heology, philosophy, sociology, Shakespeare, the popular press, the arts, etc., as well as from medicine to illustrate and develop his ideas. His first-hand knowledge of medical training, as a student and now as an administrator, and his background in divinity permit him to at once comprehend and characterize the medical student experience and to meaningfully e it into the total human experience. The range of urces and a very fluid writing style compensate for occasional departures from the medical student *routine*, while soliciting the widest possible reader interest.

In concentrating upon the medical school years, Knight is able to treat a number of themes with prehension and emphasis. Most of the *problems* challenge a medical student are well-identified nd presented from several vantage points.

Confrontation with death, for instance, is sensitively ntroduced in the second chapter, *The Cadaver: Cold ompanion But Ideal Patient*, is thoroughly explored n the tenth chapter, *Coming to Terms with One's Feelings about Death*, and is a secondary theme in other areas of the book. Likewise, developing tolerance for uncertainty, acquiring competence, and psychological problems of medical students are themes that receive consideration in depth as well as in their interrelationships.

One of the most imaginative, insightful, and well-written chapters is entitled *Profiles of Deans and of the Student*. While unlikely to command much interest outside of medical education circles, it is, by the same token, apt to strike a responsive chord in both faculty and student members of today's medical schools.

There is little to seriously detract from this book. Certain conclusions of the author may be more debatable than his declaratory style suggests. Although documentation in such instances may be lacking, one is impressed with the reasoning that usually surrounds each assertion. Despite the devotion of a full chapter to the female medical student, the book generally proceeds from a male point of view, which may serve as the best illustration of the most challenging of the problems a *minority* student encounters. Very perceptively, the author portrays attitudes and values of current students, and in this way relates the contemporary student physician with those who came before and those who will follow. *Medical Student: Doctor in the Making* will enrich the lives of those close to the student and should be interesting and informative to any thinking person.

JOHNNIE L. GALLEMORE, JR., M.D.
Associate Director of Medical Education
Duke University
Durham, N.C.

The Borderline Patient

Arlene Robbins Wolberg
New York: Intercontinental Medical Book Corporation, 1973. 283 pp., $13.75.

The diagnostic term *borderline condition* has been in use for the past 50 years in relationship to those patients who do not fit the classical categories of mental illness. Yet, increasingly one reads about it in the literature and encounters patients who do not fit the classical categories of mental illness. Dr. Wolberg traces the historical development of the borderline concept in psychodynamic and psychopathological studies of the hysterias, schizophrenias, depressions and the character disorders. In the process of doing so, she gives an excellent review of the psychoanalytic literature as it pertains to borderline patients, even though as a distinctive syndrome, the dynamics were never described.

The current literature on the borderline patients is then reviewed. Improper evaluations of borderline patients have all too frequently led to misdirected therapy. She quotes Eisenstein and Woltman who report that in their private consultations with adult cases, 30 to 32 percent fell into the borderline category. The author, as well as others currently publishing in this area, all feel that one cannot treat these patients through a transference neurosis. To do so would lead to failure, and danger of precipitating a psychotic episode. The recent work of Dr. Otto Kernberg is also reviewed and he, too, warns that a complete transference neurosis should not be permitted to develop, and that the focus of treatment

should be on the negative transference and the patient's pathological defenses.

The chapter on family dynamics emphasizes that the most severely rejected children seem to develop schizophrenia, borderlines are less rejected, but more rejected than the neurotics. The Grinker, Werble, and Drye (1968) research study is reviewed, with his four categories of borderline states and the three family types from which borderline patients emerge.

The remainder of the book is devoted to the rationale of the projective therapeutic technique of the author and the working-through process which she illustrates by actual therapy sessions with a number of her patients. Particularly stressed was a method of gradual education of the patient and his use of projective mechanisms while actively interpreting the hostile transference reactions.

Dr. Wolberg is to be commended for her comprehensive review of the literature on the borderline patient and some of the excellent suggestions she has made about treating this difficult group of patients.

HERBERT KLEMMER, M.D.
The Menninger Foundation
Topeka, Kan. 66601

Annual Review of Behavior Therapy: Theory and Practice
Edited by Cyril M. Franks, Ph.D. and G. Terence Wilson, Ph.D.
New York: Brunner/Mazel, Inc., 1973. $25.00.

This book, the first in a projected annual series on behavior therapy, represents a useful compilation of some of the best, and/or most popular and influential, articles on the subject. These are *not* equivalent classes. For example, Neal Miller's theoretical article, *Interactions Between Learned and Physical Factors in Mental Illness*, originally published in Seminars in Psychiatry, is one of the best, while Judd Marmor's, originally published in Archives of General Psychiatry and titled *Dynamic Psychotherapy and Behavior Therapy—Are They Irreconcilable?*, is one of the most influential.

The book is considerably improved and unified by what is, on the whole, a rather thoughtful and competent Editorial Commentary. There are summar critical overviews preceding each of the 10 major sections of the book, which contains 47 *chapters* or republished papers.

Some of the most thought-provoking and interesting material appears in the book's first 50 pages. Happ enough, there is a balanced and thoughtful Introduction by Lewis Wolberg (a psychoanalyst!). This is followed by a good Editorial Commentary on the nature of behavior therapy, and then by a fine chapter by Arnold Lazarus.

Chapter 2 by Joseph Wolpe is a brief rebuttal—lil the statement of his contrasting view of behavior therapy, while Chapter 3, by Edwin Locke, entitled *Is* (Wolpe's) *Behavior Therapy Behavioristic?*, argu strongly that it is not, in that nearly all Wolpe's therapeutic methods presuppose embracing introspection as a valid scientific method, and use in order to plan therapeutic strategy.

On the critical side, the book illustrates not only what is best about behavior therapy, but what is worst about it. This defect is presaged by the curious prefatory quotation attributed to the 17th century lexicographer, Ben Johnson: *Next to truth, a confirmed error does well.*

In a way, though obviously not so intended, this quotation fittingly illustrates one of the liabilities of behavior therapy—that it effectively elevates, by implication, confirmed objectivity to the level almost of truth itself. Behavior therapy also has a tendency to brashly dismiss nuances of clinical experience that are legitimate and vital sources of data in our field, even though they may be methodologically difficult to *confirm* quantitatively.

These criticisms aside, I believe that the book is a valuable collection of diverse theoretical and clinical papers, and should serve as an intellectual stimulus and challenge to the discriminating reader.

LEE BIRK, M.D.
Clinical and Research Director
Learning Therapies, Inc.
Boston, Mass.

Your Newest Neighbor May Be Your Best Friend.

Or so it'll seem with your community mental health center. It's a new type of facility, run by people in your area with initial help from the Federal government.

The nice thing about it is that you don't have to go far to get help for emotional problems when it's needed. Help like inpatient and outpatient care, hospitalization, emergency service, and public education and consultation. So far, there are 359 such centers operating throughout the country. The goal is 1,500 by 1980.

Promoting them is the National Association for Mental Health — the only nationwide citizens' organization to do so.

Your mental health association is striving to make a difference in the quality of services provided by these centers.

Join and Support Your Mental Health Association

Citizens Who Do Make A Difference

PUBLICATIONS

To order, write NAMH Publications Dept
1800 No. Kent. St., Arlington, Va. 22209

Policy and Position Statements (*Free on request*)

- ☐ ABORTION
- ☐ CHILD DEVELOPMENT CENTERS
- ☐ CIVIL RIGHTS OF MENTAL PATIENTS
- ☐ THE DISADVANTAGED
- ☐ FACILITIES AND SERVICES FOR THE GERIATRIC MENTAL PATIENT
- ☐ FAMILY LIFE AND SEX EDUCATION
- ☐ HOMOSEXUALITY
- ☐ JOINT COMMISSION ON MENTAL HEALTH OF CHILDREN REPORT
- ☐ MANPOWER
- ☐ MARIJUANA
- ☐ MARRIAGE COUNSELORS
- ☐ MENTAL HOSPITAL/LABOR-MANAGEMENT DISPUTES
- ☐ MENTALLY ILL AND THE LAW
- ☐ NATIONAL HEALTH INSURANCE
- ☐ PASTORAL COUNSELING
- ☐ PSYCHOSURGERY
- ☐ RIGHT TO TREATMENT
- ☐ STANDARDS FOR LABOR PERFORMED BY STATE HOSPITAL MENTAL PATIENTS
- ☐ SUICIDE PREVENTION
- ☐ THIRD PARTY PAYMENTS FOR THERAPISTS

Pamphlets

- ☐ CAN MENTAL ILLNESS BE PREVENTED? $2.20 per C.
- ☐ CLERGYMAN'S GUIDE TO RECOGNIZING SERIOUS MENTAL ILLNESS. $10.00 per C.
- ☐ MINISTERING TO FAMILIES OF THE MENTALLY ILL. $10.00 per C.
- ☐ THE CLERGY AND MENTAL HEALTH. $10.00 per C.
- ☐ FACTS ABOUT MENTAL ILLNESS. $1.50 per C. Basic up-to-date statistics.
- ☐ FILM CATALOG. Free. Selected films for mental health education.
- ☐ GROWING UP AIN'T THAT EASY. $1.20 per C. Dos and Don'ts for dealing with the emotionally disturbed.
- ☐ HOW TO DEAL WITH YOUR TENSIONS. $7.50 per C.
- ☐ HOW TO INVOLVE ETHNIC MINORITIES AND THE POOR IN THE MENTAL HEALTH ASSOCIATION. $12.50 per C.
- ☐ INSURANCE IN MODERN MENTAL HEALTH CARE. $5.00 per C. Current thinking on insurance coverage for mental illness.
- ☐ THE HIGH COST OF MENTAL ILLNESS. $23.00 per M.
- ☐ CHILD ALONE IN NEED OF HELP. $2.30 per C.
- ☐ HOW TO DEAL WITH MENTAL PROBLEMS. $7.50 per C.
- ☐ HOW TO RECOGNIZE AND HANDLE ABNORMAL PEOPLE: A MANUAL FOR POLICE OFFICERS. 80¢ each or $55 per C.
- ☐ SOME THINGS YOU SHOULD KNOW ABOUT MENTAL AND EMOTIONAL ILLNESS. $2.00 per C; $16.35 per M.
- ☐ WHAT EVERY CHILD NEEDS FOR GOOD MENTAL HEALTH. $1.35 per M.
- ☐ WHEN THINGS GO WRONG. $9.00 per C.
- ☐ MENTAL ILLNESS: A GUIDE FOR THE FAMILY (revised edition). 80¢ each. Handbook for families of the mentally ill.
- ☐ NAMH PUBLICATIONS CATALOG. Free.
- ☐ WHERE YOU CAN FIND INFORMATION ON MENTAL HEALTH AND MENTAL ILLNESS: A BIBLIOGRAPHY. $2.25 per C.

Joint Information Service Publications

- ☐ CHILDREN AND MENTAL HEALTH CENTERS. $6.00 each.
- ☐ ELEVEN INDICES. $4.00 each.
- ☐ HALFWAY HOUSES FOR THE MENTALLY ILL. $6.00 e[illegible]
- ☐ MENTAL HEALTH ON THE CAMPUS: A FIELD RE[illegible] $7.50 each.
- ☐ HEALTH INSURANCE FOR MENTAL ILLNESS. $2.50 e[illegible]
- ☐ PARTIAL HOSPITALIZATION FOR THE MENTALLY [illegible] A STUDY OF PROGRAMS AND PROBLEMS. Cloth: $6.00 e[illegible] 4 or more copies $5.25 each. Paper: $4.00 each[illegible] more copies $3.50.
- ☐ PRIVATE PSYCHIATRIC HOSPITALS: A NATIONAL SURV[illegible] $3.00 each.
- ☐ REHABILITATING THE MENTALLY ILL IN THE COMMU[illegible] NITY. $6.00 each.
- ☐ THE COMMUNITY MENTAL HEALTH CENTER: AN IN[illegible] TERIM APPRAISAL. Cloth: $6.50 each; 4 or more c[illegible] $5.25 each. Paper: $4.00 each; 4 or more copies $[illegible]
- ☐ THE MENTALLY ILL OFFENDER: A SURVEY OF T[illegible] MENT PROGRAMS. Patricia K. Scheidemandel and Charles K. Kanno. $2.00 each.
- ☐ THE PSYCHIATRIC EMERGENCY: A STUDY OF PATTERNS OF SERVICE, 1966. $2.50 each; 5 or more copies $[illegible] each.
- ☐ SALARY RANGES OF PERSONNEL EMPLOYED IN STATE MENTAL HOSPITALS AND COMMUNITY MENTAL HEALTH CENTERS, 1970. Patricia L. Scheidemandel and Charles K. Kanno. $4.00 each.
- ☐ LEGAL SERVICES AND COMMUNITY MENTAL HEALTH CENTERS. Henry Weihofen. $2.00 each.
- ☐ THE STAFF OF THE MENTAL HEALTH CENTER: A FIELD STUDY. Hardcover: $6.00 each; 4–9 copies $5.25; 10 or more copies $4.75 each.
- ☐ THE TREATMENT OF ALCOHOLISM. $3.00 each.
- ☐ TREATMENT OF DRUG ABUSE: A STUDY OF PROGRAMS AND PROBLEMS. $7.00 each.

(Bulk orders available from Publications Department, American Psychiatric Association, 1700 18th St., N.W., Washington, D.C. 20009. Discount for bulk orders.) The Joint Information Service is sponsored by the National Association for Mental Health and the American Psychiatric Association.

THE NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.

Founded by Clifford W. Beers in 1909, the National Association for Mental Health is a voluntary citizens' organization working for the improved care and treatment of the mentally ill, for improved methods and service in research, prevention, detection, diagnosis and treatment of mental illness and for the promotion of mental health.

Mental Health is Freedom

Freedom to feel comfortable about yourself. And right about other people. It's also the ability to meet life's demands.

Mental health, you might say, is the over-all way people get along—in their families, at school, on the job, with their friends, and in their communities. It's a happy feeling, which the National Association for Mental Health is working to achieve for everyone.

Your local mental health association is part of this effort and wants you to be a part of it, too.

Join and Support
Your Mental Health Association
Citizens Who Do Make A Difference

FALL 1974

Docket Issue
to the Librarian
R Das
2/3/75

THE INSANITY DEFENSE

SHOULD IT BE SCRAPPED?

RICHARD C. ALLEN EXPLORES THIS AS A POSSIBILITY IN A CANDID ARTICLE AND EDITORIAL ON ONE OF THE LAW'S MOST COMPLEX AND PERPLEXING RULES

Insanity is not a distinct and separate empire; our ordinary life borders upon it, and we cross the frontier in some part of our nature.

Taine

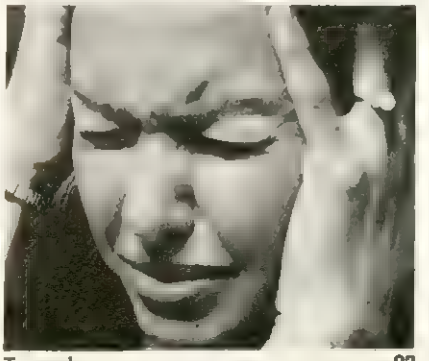
CONTENTS

Fall 1974 • Volume 58, Number 4

Defense 4

Hotline 10

Dilemmas 18



Tragedy 23

Commentary ..... Richard C. Allen, J.D. **3**

The Insanity Defense: An Uncertain Future ..... Richard C. Allen, J.D. **4**

Controversy ..... David E. Silber **8**

How to Handle Hotline Calls ..... Glen D. King, Ph.D. **10**

Essay ..... Bill Perry, Jr. **14**

Citizens Making a Difference **16**

Mental Health Dilemmas in the Age of an Ecological Crisis ..... James K. Whittaker, Ph.D. **18**

Tragedy Examined ..... Peter J. Hampton, Ph.D. **23**

Books ..... Gene Usdin, M.D. **25**

Publications **31**

Index **32**

After more than 50 years as a journal devoted principally to exchange among mental health professionals, **MH (Mental Hygiene)** in 1970 began a transition to become a publication designed for policymakers—both lay and professional—in the mental health field. The Board of Directors believes that other journals now provide effective exchange within professions and among professionals, but no regular publication exists to inform the growing number of citizens faced with major policy decisions involving future care systems and prevention.

MH is published quarterly by the Communication Department of the National Association for Mental Health, Inc. Editorial Office: 1800 North Kent St., Rosslyn, Arlington, Va. 22209. Circulation Department: 49 Sheridan Ave., Albany, N.Y. 12210. Rates: $10 per year (Canada, $10.25; other countries, $10.50). Single copy, $3.

Printed in Baltimore, Md. Second class postage paid at Arlington, Va., and additional mailing office.

Credits: *Front Cover*—Michael T. Goorevitz; *4, 15, 19, 21, 23*—H. Armstrong Roberts; *10, 11, Back Cover*—Day Walters Photographic Illustration.

MOVING? PLEASE NOTIFY US 4 WEEKS IN ADVANCE

Attach mailing label here, fill in new address below and send to: MH SUBSCRIPTION OFFICE, 49 Sheridan Ave., Albany, N.Y. 12210.

Name_____

New Address _____

City _____ State_____ Zip _____

TO WRITE ABOUT YOUR SUBSCRIPTION: Change of address, billing adjustment, complaint, renewal—address: MH SUBSCRIPTION OFFICE, 49 Sheridan Ave., Albany, N.Y. 12210. (Attach present address label in space provided. If you are receiving duplicate copies, please attach both labels.) This will help us identify you quickly and accurately.

TO ORDER A NEW SUBSCRIPTION: Check box ☐ and use form above. Mail to MH SUBSCRIPTION OFFICE at the address given. Or for faster service and attention, you can simply call (518) 436-9686. Subscription rate: U.S., 1 year $10.00; in Canada, $10.25; other countries, $10.50.

TO WRITE ABOUT EDITORIAL CONTENTS: Address: MH, 1800 N. Kent St., Arlington, Va. 22209.

COMMENTARY

Richard C. Allen, Editor-in-Chief

My article in the current issue (The Insanity Defense: An Uncertain Future) advocates abolition of the insanity defense, for reasons I will not repeat here.

In my view, abolition must be accompanied by a massive infusion of behavioral science resources into the criminal court-correctional system. This was recommended nearly 50 years ago in a joint position statement of the American Bar and American Psychiatric Associations (calling for, among other things, a psychiatric service attached to every criminal and juvenile court, and every penal and correctional institution: with psychiatric reports on every person convicted of a felony, prior to sentencing). Until society is willing to provide these resources (which would cost less than we annually pay for cosmetics and pet food) we must, it seems to me, continue to have an insanity defense—wasteful and inaccurate as it is. And the role of insanity should conform as closely as possible to contemporary definitions of mental illness and mental retardation.

Although my article is critical of the "modern" *Durham* and *ALI* rules, I think either is to be preferred to the "right and wrong" M'Naghten standard. The M'Naghten rule simply excludes too many defendants who are seriously disturbed, and whose pathology brought about their criminal acts. Without treatment, they are likely to emerge from prison more disturbed —and more dangerous—than when they went in.

Indeed, as a practicing trial lawyer, I have myself advocated "liberalization" of M'Naghten. Some years ago, I represented an 18-year-old Kansas farm boy, Lowell Lee Andrews, who was charged with the murders of his parents and sister (Truman Capote includes an excellent description of the case in his book *In Cold Blood*). Andrews was diagnosed—by the prosecution as well as the defense psychiatrists—as a schizophrenic, and the M'Naghten rule, with its cognitive preoccupation ("Did he know . . . was he aware?") is particularly difficult to apply to schizophrenia. Andrews was a freshman at Kansas University and probably could have described pretty accurately the legal definition of first degree murder. Thus, the M'Naghten rule, strictly and literally defined, was held inapplicable to him. The Supreme Court of Kansas, affirming his death sentence, declared:

> *The law recognizes no form of insanity, although the mental faculties may be disordered or deranged, which will furnish immunity from punishment for an act declared by the law to be criminal, so long as the person committing the act had the capacity to know what he was doing and the power to know that his act was wrong.*

Lee Andrews' problem was not lack of intellect, but rather that bizarre "splitting"—not of the personality into two separate individuals, as is the popular conception of the disease, but of thinking and emotion —which may characterize that illness. Thus, Lee—living within the unreal and narcissistic world of his daydreams—had no more feeling about taking the lives of the three persons who loved him most than had they been insects on a sidewalk under an indifferent foot. Nor had he any more concern for his own life than he had for theirs.

I entered the case after his conviction, sentence of death, and affirmance of that sentence by the sate Supreme Court and represented Lee for the next 3 years—through many court hearings and two appeals to the U. S. Supreme Court. In my first meeting with him, when he was within 12 hours of that walk up the steps of the scaffold, and after having described the killings in the rather bored tones of a play-by-play announcer of a dull football game, he looked at me as I was about to leave and said: "Keep in touch, will you? Sure going to be interesting to see how this thing comes out."

No, I am not indifferent to the arguments for a liberalized insanity rule. For 3 years I used them all in what was ultimately an unsuccessful effort to prevent the hanging of a young boy for the "crime" of mental illness. I will never forget those frantic, last-minute appeals to the Governor after the last court rejection of our argument that the M'Naghten rule—as the Supreme Court of Kansas construed it—is a denial of due process of law. Fortunately for Lee, his illness blunted the horror of those last days, hours, minutes before they broke his neck in the name of law. Just before he pulled the switch, the warden (who had attended the first habeas corpus hearing, and had told me afterward that it had convinced him that the boy should be hospitalized, not executed) asked, in that pathetic helplessness of the compassionate executioner, whether there was anything . . . anything . . . he could do for Lee. The last words of Lowell Lee Andrews were: "Yeh, hold my glasses." ■

THE INSANITY DEFENSE:

AN UNCERTAIN FUTURE

By Richard C. Allen, J.D.

More than 125 years ago, a psychotic named Daniel M'Naghten attempted to assassinate the Prime Minister of England, Sir Robert Peel, but instead shot and killed his private secretary, whom he mistook for Peel. There had been a series of attempted assassinations of the Queen's ministers and even of members of the Royal Family. So when M'Naghten was found not guilty by reason of insanity at his trial, Queen Victoria called the judges of England before the House of Lords to explain their conduct. In those days, the Queen was as powerful as is her counterpart on contemporary chess boards, and the judges were under considerable pressure to *tighten up* the insanity rules.

Fourteen of the fifteen judges concurred in what has come to be known as the M'Naghten Rule—a rule that became the prevailing test of insanity in England and in this country. Essentially, it says that a defendant is to be held criminally responsible for his acts unless it is proved that by reason of mental disease he did not know the nature and quality of his acts or, if he did, that he did not know they were wrong.

The rule, which is still the test in most American jurisdictions, has been criticized on a number of scores:

- It is too restrictive, requiring a degree of disorientation found in only a very small percentage of even the most seriously mentally ill persons;
- It focuses on one symptom only: impairment of the cognitive function, ignoring the emotional and volitional impairments that far more frequently characterize mental illness;
- It is preoccupied with moral blameworthiness (knowledge of "right" and "wrong"), rather than with scientific diagnosis and prognosis;
- It is phrased in absolute terms—yes or no, black or white—without recognizing shades of gray; and
- It unduly restricts the scope of psychiatric and psychological testimony.

Then, in 1954, Judge David L. Bazelon announced, in *U.S. v. Monte Durham*, a new rule for the District of Columbia, under which expert testimony would no longer be confined to the parameters of the M'Naghten standard. Instead, the jury would be presented with a "simple" causation test: Was the act the product of mental disease or defect? For bringing the law into accord with "modern" scientific concepts of the human personality, Judge Bazelon was hailed as a great reformer.

But Durham created as many problems as it resolved:

- What *is* a "mental disease or defect?" Only psychoses? Only what is defined as a "mental disorder" in the American Psychiatric Association's Diagnostic and Statistical Manual? (And if so, has the law abdicated its decision-making role?) Are sociopaths included? (And if they are, is repeated criminality an automatic defense?)
- What does "product of" mean? And how can any act committed by one suffering from a diagnosable mental disorder be anything other than causally related to his mental pathology?

It was widely believed that *Durham* "opened the door" to evasion of criminal penalties by malingering defendants. In May 1973, President Nixon referred to "unconscionable abuse by defendants" of the insanity defense as one of the major problems in the criminal justice system. Yet, in the District of Columbia—the principal malfactor in terms of the liberality of its insanity rule—acquittals by reason of insanity have amounted to less than 2 percent of all criminal charges terminated, and jury verdicts of not guilty by reason of insanity have averaged only around 3 per year. Moreover, attorneys representing defendants in criminal cases know that convincing the truly mentally impaired offender to raise the insanity defense is a far more frequently encountered problem than dissuading the malingerer from employing it illicitly.

But the pressures mounted to "tighten-up" Durham, much as Queen Victoria urged a more stringent rule on the judges of England in 1843. And the clear course seemed to be toward the rule that had found acceptance—in one form or another—in most of the other Federal courts. This was the rule enunciated by the American Law Institute (ALI) in its "Model Penal Code:" that defendants should be exculpated only if "substantially deprived of capacity" to appreciate the criminality ("wrongfulness") of their conduct, or to conform their conduct to the requirements of the law.

The "ALI Rule" met one of the objections to M'Naghten—failure to recognize gradations of impairment—by employing the phraseology: "*substantially* deprived of capacity"; and one of the difficulties encountered in administering Durham—ambiguity of the causation factor ("product of")—by providing instead both a cognitive (appreciation of criminality) and a volitional (conform one's conduct) standard.

On June 23, 1972, in *U.S. v. Archie Brawner*, the United States Court of Appeals for the District of Columbia Circuit finally abandoned the Durham experiment and adopted the ALI insanity rule (augmented by a rule of "partial responsibility"*). But in doing so, both the author of the majority opinion, Judge Leventhal, and the concurring judge, Judge Bazelon, observed that they did not believe the adoption of a new set of words would either affect a substantial number of verdicts or resolve the manifest problems of the insanity defense.

In an article published in the *Washington University Law Quarterly* shortly after the *Brawner* decision was announced, I referred to *Brawner* as "new lyrics for an old

The author is Editor-in-Chief of MH and Chairman, Department of Forensic Sciences, The George Washington University.

* Under the rule of partial responsibility, the degree of the crime may be reduced on the basis of psychiatric evidence of inability to form the criminal intent required of the higher degree of the crime charged.

continued

tune." Recognizing that the words of *Brawner* are perhaps less ambiguous than those of the former *Durham* rule, and are certainly less alarming to those who fear misuse of the defense by conniving defendants, it was observed that the "tune" remains the same.

That is, that the "responsibles" can be separated from the "irresponsibles" and that verdicts in criminal cases should distinguish between persons suffering from "mental illness" and those with "free will" on the basis of the wording of an "insanity" test rather than on a determination of the treatment-correctional modality most likely to effect behavioral change.

A distinguished lawyer has urged that legislatures amend the law so that the question of insanity be determined by an expert tribunal *after* conviction. He argued that no jury is competent to determine whether a defendant could judge between "right" and "wrong," but rather should confine its decision to whether he in fact committed the crime charged, "for whether he committed it sane or insane, the result is . . . that the safety of society requires that he should be placed in seclusion for such a period as will promote the joint ends of personal reformation and the preservation of the well being of the community at large."

The suggestion seems at once both novel and revolutionary. In fact, however, it was first proposed by Sir Francis Wharton less than two decades after the House of Lords' opinion in M'Naghten's case. Abolition of the insanity defense has been advocated since by a growing number of scholars in both the legal and medical professions—the latter group including psychiatrists of such widely divergent views as Thomas Szasz and Karl Menninger!

Why abolition? Some of the arguments may be summarized as follows:

- Trained mental health personnel, especially psychiatrists, are in critically short supply. Devoting their services to assistance in disposition and treatment seems far more sensible than assigning them to making restrospective judgments of "responsibility."
- All of the prevailing insanity tests are vague, inviting semantical speculations and moral judgments in the guise of factual determinations.
- None of them offers much in the way of a guide to determine "blameworthiness" or, the much more important question, whether an offender should be institutionalized and, if so, where and with what rehabilitative program.
- It makes good therapeutic sense to treat offenders as responsible for their conduct, rather than as helpless victims of "illness." Indeed, it is the objective of psychotherapy to assist the patient to assume direction of his life rather than to evade the conflicts of reality.
- The insanity defense fails to recognize the influences of social factors in restricting behavioral choices (e.g., the offender suffering from delusions is exculpated, but the defendant suffering from a ghetto environment and a delinquent subculture is not).

THE DICHOTOMY WHICH THE LAW HAS TRIED TO MAINTAIN BETWEEN THE "MAD" AND THE "BAD" IS A PATENT ABSURDITY

Among the objections to abolition is the contention that the behavioral sciences have not advanced far enough to provide answers to such questions as moral culpability, dangerousness, and treatability. But if we are awaiting a scientific breakthrough on questions of moral blameworthiness, we will doubtless still be waiting on Judgment Day (when, presumably, the only authoritative decision on that score will be issued).

And surely the treatment and release decision can more appropriately be made after expert study and diagnosis of the offender rather than by a legislature's prospective judgment, based on a description of a piece of behavior ("anybody who does this . . . gets that") or through our present system of sentencing, prison and parole which—as indicated by the statistics on recidivism—often works against both protection and rehabilitation.

Further, it is argued that abolishing the insanity defense would weaken the deterrent impact of the criminal law. But the reverse is true. It is the present haphazard and discriminatory insanity defense—postponing punishment for some, and avoiding it for others (who "couldn't help" what they did) that weakens the deterrent value.

One writer has urged that "eliminating the insanity defense would remove from the criminal law and the public conscience the vitally important distinctions between illness and evil." To which I can only observe: Right on! The dichotomy which the law has tried to maintain between the "mad" and the "bad" is a patent absurdity, whose loss will be little missed, save by professional testifiers and psychiatrist-baiting cross-examiners.

Perhaps the most [illegible] objection to continuation of the quest for separation of the "sane" from the "insane" is that humanity cannot be divided into such discrete categories. If the elusive group we are seeking to define with our reformulations of rules are those without "free will"—without the capacity to choose to obey the rules of society—then where are they to be found? And how?

The "sickest" of us—in the most remote back ward of a primitive state hospital—may have some capacity to respond to rules, some consciousness of social accountability. And the "wellest" of us may have areas of ego weakness in which our range of behavioral choices is narrowed by our hereditary equipment

and our experiences. In any event, how can a lay jury be expected to make a diagnosis and prescription of treatment on the basis of a few days or weeks of trial, especially where the facts are filtered through the mechanisms of adversary inquiry and the principal focus is moral blameworthiness?

A few years ago, a dear friend of mine, Dr. Seymour Pollack, appeared as a guest speaker in my course on Criminal Law. He told the students about his experiences as witness for the prosecution in the Sirhan Sirhan case. Opposing him, as witness for the defense, was another distinguished California psychiatrist, Dr. Bernard Diamond.

Both made heroic investments of time—literally hundreds of hours of clinical interviewing, examination of reports and documents, conferences with counsel, and testifying in court. To what end? Was society one whit better protected by it all? Was Sirhan Sirhan's condition—whatever it may have been—improved in the slightest degree?

My class enjoyed the discussion and, I think, learned a great deal about the effective presentation of psychiatric testimony. But they perhaps shared with me the thought that the devotion of comparable time, by these eminent forensic specialists, to the provision of consultation services to probation officers, establishing group therapy programs in correctional institutions, or setting up halfway houses might have been far more socially useful than was their testimony at trial.

The author's first collaborator in teaching law and psychiatry, many years ago at the Menninger School of Psychiatry, Dr. Joseph Satten, put it this way:

> The psychiatrist can make his greatest contribution in legal situations if he enters after the question of guilt and innocence has been resolved and when the only question is what to do with the individual in his own and society's best interest. In other words, the psychiatrist can do the most good when he remains in his clinical, treatment-oriented role.

REGARDLESS OF WHAT HAPPENS TO THE INSANITY RULE, THE FUTURE OF THE MENTALLY IMPAIRED OFFENDER IS OF GREATER IMPORTANCE

There is, of course, a danger in all this—that of developing a *Clockwork Orange*-like therapeutic state. It is a real problem, but not insoluble. If the present system of determining "insanity" is to be abandoned for one in which • the triers of fact decide only the factual questions of who did what to whom, whether the thing done was proscribed by law, and whether the whole process of proof conforms to due process safeguards; and in which • the disposition decision is made after trial by a more expert tribunal, after more intensive study than can be provided via the trial process, then that decision too must accord that elemental fairness subsumed in the phrase "due process of law."

There must be provision for notice, representation, a right to independent evaluation, hearing, and judicial review. For the judgment is not alone medical or psychiatric, but it involves social and legal perspectives as well.

Society has the right to decide where it will spend its limited chips. If, for example, the optimal treatment for a given offender is one-to-one psychotherapy three times a week for a period of years, society has, it would seem, the right to say that it would prefer to devote its resources to other things (say, school mental health programs), and to take its chances with more traditional handling of the offender. And, if mental pathology, or the likelihood of repetition of the offense were the only criteria for release, most first degree murderers would be released almost immediately, and most exhibitionists would be imprisoned for life.

Yet there is a social interest at stake, which may well require a period of punitive custody for any offense as serious as murder, and one which may well require assumption of the risk that an exhibitionist may repeat his offense under some future stress, where the only alternative is life imprisonment.

The United States Court of Appeals for the District of Columbia Circuit has long been in the forefront of forensic psychiatry. In the depression era, it "liberalized" M'Naghten through the addition of the "irresistible impulse" rule; in 1954 it was acclaimed for the Durham test of "insanity;" and in 1972 it adopted a new, and rather complex, formulation—the "Brawner Rule." But Brawner represents a way station, rather than a terminal point. What the future holds is uncertain. One possibility has been explored here—abolition of the insanity defense.

Psychiatrists used to be called "alienists." And those whom they treated were regarded as "alien"—to be identified, separated from the "sane," and shuttled off to some remote, secure place. Regardless of what ultimately happens to the insanity rule—whether it is further refined, substituted for, or scrapped—the future of the mentally impaired offender is of infinitely greater importance. Today, whether he is declared "sane" and sent to prison, or "insane" and confined in a prison-mental hospital, the result is likely to be the same: custodial detention rather than treatment. No reformulation of words can substitute for the care that has been so long denied. The Roman poet Terence said it simply and well: *I am a human being, and nothing that is human is alien to me.** ■

* Portions of the foregoing first appeared in Allen, "The Brawner Rule—New Lyrics for an Old Tune," *Washington Univ. Law Quarterly*, Winter 1973, p. 67.

CONTROVERSY

By David E. Silber

OVER THE CRIMINAL JUSTICE SYSTEM in this country holds a number of important implications for today's mental health worker. The old debate over how to view criminal offenders, always lively and occasionally acrimonious, has taken a new turn in the past decade or so. The argument used to be over whether criminals were sick and thus ought to be treated instead of punished) or bad. The new question is concerned with psychiatric treatment of offenders: • is it an encroachment on civil liberties and • is the treatment conception psychologically sound? The issues are complicated and interlocked, emotionally charged, and important to society. Before going to the question of treatment and roles for treatment workers, let's review the arguments.

Criminal behavior is symptomatic of psychological disturbance. This *was* the enlightened liberal position. Most interpretations of criminal behavior as disturbed are made in a reformist spirit, usually coupled with appeals to radically change the criminal justice system. Proposals usually include changing the court system, changing the role of mental health workers, and transforming the prison system.

Their alternative proposals include • pre-criminal detection, • informal adjudications, • substitution of indefinite sentences for fixed or determinate sentences, and • employment of psychotherapy in one form or another, including environmental manipulation, guidance, and education. In short, the general purpose of these proposals would be to provide settings where the man, rather than the deed, is adjudicated and treated.

To a growing body of civil libertarians, these proposals are appalling and pose a challenge to personal freedom occasioned by the growth of what they call the *therapeutic state*. Among the points they make are the following:

- Informal, civil proceedings jeopardize a person's basic rights ordinarily guaranteed under criminal law. Such rights include the right to: counsel, specified indictment, time to prepare a defense, trial by jury, be present during the proceedings, confront adversary witnesses directly, and to be judged solely on the basis of innocence or guilt.
- Commitment for an indefinite period is a judgment against the person—not the deed—and, as such, represents a step toward totalitarian social control.
- Once committed, a person loses many civil liberties, and is vulnerable to enforced treatment and mistreatment. Indeterminate commitment to a treatment-oriented prison augments their problems.
- Psychiatry and clinical psychology contain inconsistent, contradictory views of human functioning, so that any psychiatric stance in a legal proceeding may well (and in good faith) be opposed by another psychiatric stance.
- Treatment programs are widely carried out without theoretical rationale or solid empirical support. Little is known concerning the relative efficacy of various treatment programs if indeed they even work. An especially problematic area is physical intrusion into the body as a way of changing behavior, such as occurs with electroconvulsive shock treatment, electrical stimulation of the brain, injections of noxious substances during aversive conditioning, and psychosurgery of one kind or another.
- *Mental health* concepts, as uncritically applied to convicted persons, are not based on medical considerations but rather on moral and ethical value systems.
- Coercive treatment programs stand little chance of success precisely because they are coercive.
- Psychiatrically oriented institutionalized treatment programs are important have failed dismally, yet are total institutions—as are prisons—and are often even more degrading and dehumanizing than prisons.

These objections leave unsolved the problem of what to do with and for the convicted offender so as to provide correctional rather than retributive experiences during imprisonment. And they completely ignore the question whether the individual criminal is in a position to perceive what is best for himself.

An indirect result of these arguments, however, is that they make it appear that treatment and therapy are the order of the day in correctional facilities. Mental health workers in the adult correctional system are few and far between, and treatment is the exception rather than the rule.

Let's now examine what the role of the mental health worker in the criminal justice system ought to be, what activities might be expanded, and what avenues for staffing might prove fruitful.

First, the mental health worker should become very leery about testifying in court. He ought to avoid doing what he patently cannot:

Mr. Silber is with the Psychology Department, the George Washington University, Washington, D.C. 20006.

render a *post hoc* judgment of psychological status.

Similarly, the mental health worker ought to exercise extreme caution before suggesting mandatory treatment programs as substitutes for imprisonment. Removal from society is punishment and mandatory treatment programs, with indefinite commitments, constitute potentially greater punishment to the individual than determinate imprisonment. Even the fact that such treatment programs would be controlled by the state health or social welfare agency is a questionable advantage, since abuses to patients could more easily masquerade as *treatment* and elude legal detection.

Research into effective methods of treatment ought to be encouraged, but the research personnel should be drawn from staff outside the correctional setting. The mental health worker in the correctional institution ought to function as an ethical watchdog, to discourage dangerous programs. There are enough innocuous techniques available which have not received adequate scrutiny so that such methods as, for example, aversive conditioning using anectine can be eschewed for a very long time. Here are some specific suggestions concerning treatment in corrections.

DIAGNOSTIC AND RECEPTION CENTERS. Increasingly, prisoners are being sent first to these centers. To impact on the prison career of the inmate, diagnosis and classification should occur as soon as the offender is incarcerated. The same panoply of professionals should have contact with the prisoner as in a well-run mental hospital, with the results being discussed at a case conference. Major decisions concerning diagnosis, therapy, and placement within the system would be made there, and a particular *package* tailored to the individual would be arrived at.

The inmate then should be given feedback; diagnosis is too often a one-way street. This is a particular danger in corrections, where hostility and suspicion are excessively present anyhow. The center staff ought to use the feedback technique to motivate the prisoner to get involved in his own rehabilitation. Enough general evidence exists to conclude that if a prisoner is treated as a human being with rights and dignity, he will more often than not respond in a like manner.

TRADITIONAL PRISON SETTINGS. Within the penitentiary and reformatory, the mental health worker can be a treatment source and *system challenger*. As a system challenger, he ought to goad the administration to eliminate retrogressive and abusive regulations; as a positive contributor, he should intervene to work on the attitudes and behaviors of the custodial staff towards the offender. Such activities would include in-service training for current staff, human relations instructions to new guards, role-playing sessions, and psychological instruction. In other words, the mental health worker stands outside the institutional hierarchy.

By staying on the periphery, the mental health worker can make his contribution most effectively. This is neither *radical* nor anti-Establishment, but simply the recognition that treatment works best when the therapist is not identified as a cog of the system by the inmate. Thus, activities such as sitting on disciplinary boards, writing parole recommendations, or acting as an information conduit to the administration are not properly within the treatment worker's pervue.

Mental health workers can serve as informal counselors to self-help groups such as Alcoholics Anonymous or the Black Muslims. Ethnic-pride groups such as the Black Muslims can have a profound effect on prisoners, and mental health workers should feel free to offer aid. Two other activities that the treatment worker should do, but probably won't be allowed to, are arrange • human relations seminars between inmates and guards, and • couples groups in the prison which include both inmates and their spouses (or fiancees).

PARTIAL-RELEASE AND POST-RELEASE SETTINGS. The need to confront the social realities and pressures on ex-offenders in their readjustment to street life marks the partial-release and post-release efforts as perhaps the most important correctional and treatment settings. Two important innovations in the recent past have been the half-way house (usually in an urban setting) for non-dangerous offenders and the work-release program (usually operated out of an honor camp). Counseling—especially experientially oriented group therapy—can be crucial here in alleviating the great strain placed on someone who is *in* a free environment, but not *of* it.

All the foregoing makes no sense at all, given the current staff situation in the correctional system. Recruitment is hampered because salaries are relatively low, prestige is low, and prisons are frequently located away from urban areas, where professionals like to locate. There are, however, a number of relatively inexpensive remedies available. Perhaps the single most neglected resource is the university-based professional training program. All programs in clinical psychology, social work, and psychiatry require significant amounts of field experience. There is no reason why correctional facilities cannot function as training centers.

A second possibility is for the Department of Corrections to underwrite the cost of professional education in return for a commitment to work for a number of years following graduation. This system seems to work for the armed forces and the VA, many of whose career professionals were recruited that way.

Interrupting the cycle of arrest, conviction and re-arrest is crucial; and to achieve that interruption, the correctional systems must be changed and changed rapidly. Offering full mental health services at every stage of the prison experience —from sentencing to post-release— can help achieve this goal while offering satisfying roles for mental health professionals within the criminal justice system. ■

Some Helpful Hints For Dealing With a Variety of Clients

HOW TO HANDLE HOTLINE

By Glen D. King, Ph.D.

ONE of the most exciting new services that has developed in the field of community mental health in recent years is telephone counseling. In many metropolitan areas, it goes under such names as telephone emergency service, suicide prevention service, youth emergency service, and hotline.

In my experience training telephone counselors, the most frequently asked questions seem to be: *What do I say, why should I say it, and how do I say it?* If you yourself have had similar questions, here are some strategies and actual phrases that I have found useful in dealing with clients over the telephone. In this respect, there are a few general points to keep in mind whenever telephone counseling is being considered.

Regardless of all the theory and training, when it comes right down to the ring of the telephone—and the beginning of interaction between novice counselor and client—the usual response of the counselor is a mild attack of anxiety.

The initial part of the call is often very important, because it sets the stage for what happens later. Counselors who talk in an anxious manner will arouse anxiety in their client that will, in turn, make the counselor more anxious. It is perfectly legitimate to feel anxious, but a counselor should not be carried away by the initial feelings of anxiety. Most novices seem to feel anxious, because they fear they will not know what to say or that they will somehow harm the client. Behind these feelings seem to be the somewhat unconscious fears of failure or not being liked by the client.

A good place to start is by picking up the phone. The salutation is important. I prefer something like *Telephone Counseling Service, John speaking.* This tells the usually anxious client that he or she has reached the right number for help and that against the cold anonymity of the phone, there is a human being with a first name. It may be advisable to give first names only, since clients have been known to call counselors at their homes when they have found out their names and addresses.

Now that you have answered, the next step is to wait and listen very carefully, paying particular attention to the tone and quality of the client's voice as well as to the content of what he or she is saying, and the feelings they are eliciting from you apart from your own anxiety. At this point, there are a number of phrases you can open up the conversation with and also use to periodically keep the interaction going.

The phrases involve a reflection of the appropriate feelings that the client seems to be presently experiencing. These phrases include *You seem to be pretty upset; You seem to be feeling very angry; You seem to be frightened; You seem to have strong feelings about that*; or *That must be a great disappointment for you.*

Dr. King is currently Assistant Professor in the Community Clinical Program in the Department of Psychology at Auburn University. He has been associated with the Telephone Counseling Service in Tallahassee, Fla., Hotline in Charleston, S.C., the Walk-In Counseling Center in Minneapolis, Minn., and Crisis Center in Auburn, Ala.

All of these phrases as used have three effects. They tell the client that the counselor understands how the client feels. Second, the counselor is allied with the client, which is especially important if the client is angry or suspicious. Third, it gives permission for the client to deal with his feelings, which may be most disruptive in his life at present.

To increase the rapport and, if the client is suicidal, to gain information, sometimes it is advisable to get the person's first name. An approach that is usually successful is *This sounds like something that troubles you a great deal and something we might spend some time on. I've introduced myself, I'm John. It might be easier to talk if I knew your first name.*

Let's turn to the techniques and strategies used for various types of callers.

CALLS

THE SILENT CLIENT will call and say *hello* and then wait until the counselor's anxiety motivates him to fill the void with questions. This type of caller has learned that in our culture silence between two people causes anxiety, and it is not long before the other member of the dyad begins to speak. However, the counselor should *not* take the majority of responsibility for the conversation nor should he allow the interaction to lapse into complete silence.

After a reasonable silence, one approach might be *It appears that you have difficulty talking about what may be bothering you* or *It seems difficult for you to talk to people.* At some point, if the silence continues, it may be necessary to share your reactions with the client: *I am feeling somewhat frustrated over your lack of response, and I could see myself getting angry with you. I wonder if other people have reacted to you in this way?*

Finally, if the silence continues, it may be necessary to terminate the call, which is more therapeutic than to continue attempts to elicit responses. Such a termination might go *I cannot help you when you are silent, but I suspect that you have a great deal of trouble talking to people and this is part of your problem. I understand that and when you can feel more at ease in talking to us, we will be ready to listen. I am going to hang up now, but I or somebody else on the staff will be waiting to hear from you again.*

THE QUESTIONING CLIENT will avoid dealing with his own problems by asking the counselor questions. These questions generally fall into three categories. The first has to do with questioning the counselor's competence and may take the form of *What qualifications do you have?* These questions should always be answered honestly, but the information should be given only if the client asks for it. Also, the counselor should provide only answers regarding his training, without elaboration on the qualifications of supervisory personnel. In addition, it is often advisable to be aware of secondary purposes of questions, for a suspicious, questioning caller may have had a previous bad experience with professional quacks and charlatans.

The second category of questions has to do with personal information, such as the counselor's age, marital status, number of children and, sometimes, even sexual practices. Again, these questions are often designed to help the client avoid dealing with his own problems, and I usually make an interpretation something like this: *We could talk about me for a good while, but that is not going to help you deal with what is troubling you* or even stronger, *Your questions of me seem to serve the purpose of avoiding talking about problems that must upset you very much.*

Opinions are varied regarding whether and how the questions should be answered. A helpful rule to follow is to answer any question about yourself that is general public knowledge. Avoid answering more personal questions by simply saying *I do not answer questions about my personal life, because the purpose of my being on the phone is to help the caller deal with his problems, not mine.*

The third category of questions includes all those designed to get the counselor to tell the client what to do. There are two usual outcomes if the counselor answers the questions. The first, if the counselor's advice works out satisfactorily is that the client feels the counselor was a success and he (the client) was not because, after all, it was the counselor's idea. The second outcome occurs when the couselor's advice does not work out and then, of course, the results are the counselor's fault. The client who asks *What do I do?* usually seeks and gets advice that he already knows will not work. Yet, he follows it anyway, just so he can later accuse and berate his advisor. *continued*

X, Y, Z PROBLEM CLIENT. Those who fit into the category just described often become the *I have problems X, Y, and Z, What do I do?* clients. As pointed out before, the telephone counselor should avoid giving advice on solutions to problems, because the client must learn to take on that responsibility and how to approach solving problems in times of crisis. There are generally three levels at which such problems can be addressed.

The first involves merely asking the client, *What alternatives have you considered?* This helps both counselor and client clarify the possible solutions thus far dealt with by the latter. A good follow-up question such as *How do you feel about each of these alternatives?* will further help the counselor and client clarify the motivations of the client pro and con for acting on each alternative. Often, it becomes immediately apparent that the client favors one line of action more than any other, and this should be reflected by the counselor: *It seems that you really have already decided what to do since you feel that A is your best alternative.*

Occasionally, clients are not able to define or consider what alternatives are available to them, and the second approach may then be initiated. This approach is illustrated by the statement *Other people whom I have known in similar situations have done this. How would you feel about that?* It is extremely important to add the question concerning the client's feelings about the suggestion, since this gives him a certain amount of *psychological space* to accept or reject the suggestion, and his decision constitutes taking responsibility for action. This approach also avoids forcing a plan of action on the client that may not be appropriate to his needs.

Finally, on rare occasions, a client may not respond to either of the above approaches, and direct suggestion or direction may be necessary. Such suggestions should still include the idea that the responsibility for the action lies with the client and no one else. An example might be *It is your decision to make because you will be responsible for what happens, but I would suggest.* . . . The strategy necessary to deal with this client involves getting him to consider viable alternatives and make realistic decisions using the counselor as a *sounding board.* Hopefully, this will result in getting the client to face his problems in a crisis situation, and teach him how to approach the problem in a rational manner.

THE HOSTILE CLIENT can be a particular problem, especially for someone who is a novice at telephone counseling. A common mistake in dealing with the hostile client is to become immediately defensive and try to explain away his angry retorts. However, it should be recognized that these clients typically relate to others in the same hostile, aggressive manner, and this constitutes a great deal of their interpersonal problems. A second mistake that is often made is to react to the client with the anger that he often provokes in others by his hostile interpersonal approach. This will only result in self-righteous indignation and more anger in the client, and also a perceived justification for his hostility—*You have to be mean, because everybody else is.*

The strategy in these cases is designed to make the client feel that the counselor understands his feelings. For instance, you might say something like *You sound really upset and angry about all this* or, if he has already explained why he is angry, *I guess I can understand why you are so angry.* Invariably, the anger will melt away and then a more rational approach can be pursued to deal with the roots of the problem.

THE SEDUCTIVE CLIENT makes his or her bid to stem off loneliness by attempting to arrange a rendezvous with the telephone counselor. This sometimes is a tempting problem for the counselor and should not be taken lightly. Making dates or arrangements with telephone clients, either for romantic or ostensibly therapeutic purposes, is totally inappropriate and can only lead to an unprofessional reputation for the telephone counseling center at the very least. The strategy that seems to be appropriate here is to deal with the hidden message of the caller—that he or she is lonely to the extent that usual and desperate attempts to get close to another human being are being made.

THE ILL-DEFINED PROBLEM CALLER is upset about something but cannot or will not tell the counselor what the problem is. Two successive approaches are appropriate.

First, the counselor should be sensitive to the client's inability to express himself, and this sensitivity might take the form of *It seems that you have great difficulty talking to me about what is upsetting you.* This is especially true if the caller is of the opposite sex. Very often, clients will have difficulty discussing a problem area with a counselor of the opposite sex, because the problem is a sexual one, i.e., abortion, premarital intercourse, etc.

In these instances, it is very helpful to say something like *I wonder if you are having difficulty talking to me because I am a man?* or *I am wondering if talking about your problems with me is embarrassing for you?* Usually if the client can begin the interchange by talking about the difficulty in just discussing the subject, the actual substance of the problem will become quickly apparent.

The second step in the approach should be initiated if the first step was inappropriate or yielded no results. It involves communicating to the caller the feelings of frustration that arise as a result of not being able to determine the specific problem. This may take the following forms: *I would like to help, but I feel frustrated because I don't know exactly what you want from the telephone service* or *What would you like us to do for you?* or *What would you like to see happen as a result of our talking here?* If the client does not respond to this approach. it is wise to terminate the call in a kind but firm manner.

THE CHRONIC CALLER is a special problem that plagues most telephone counseling centers sooner or later. I have generally found that these clients fit two categories.

The first includes those marginally adjusted, extremely dependent people whose interpersonal skills are so poor that they can only establish a relationship with a professional listener, such as a psychotherapist or a telephone counselor.

These clients are long-term therapy candidates, and every effort should be made to get them to the appropriate mental health facility. Very often, however, in the process of getting them in for face-to-face professional services (which sometimes takes months), they call day after day or even several times a day with no definite problems—*just to talk.*

In the past, it has been necessary to limit these people to one call per day for a specified period of time, such as 15 minutes. The entire staff must cooperate on this and be consistent in the treatment of these clients. In addition, it may be advisable to limit the substance of the calls to the suggestion that the client get professional help.

The second category of chronic callers is usually comprised of clients who are seriously disturbed, very often schizophrenics. These clients will call and lament about the dead squirrels in the sink, or the purple spiders on the wall, or the FBI being after them. Again, these people need to be repeatedly and seriously encouraged to seek treatment at a clinic or a hospital.

During the process of this strategy, it is necessary to help these clients distinguish reality from hallucination and appropriate conversation from psychotic jibberish. In this regard, the counselor may have to say such things as *What you are saying does not make any sense. Can you say it in a different way so I will understand?* It is important to get these clients to deal with real-life problems in an understandable and rational manner and not to let them dwell in psychotic thought process, hallucinations or delusions.

THE PRANK CALLER is usually ignored, avoided, and detested by the telephone counselor but, in fact, has a problem like any other client. If they stay on the phone long enough, I usually deal with such calls with *You have probably called the right place, as making prank phone calls can be a problem like any other. Perhaps we could talk about this.* It is important to remember that whatever the overt purpose is for any call, the client may be asking for help in a different manner.

THE SECOND-HAND CALLER is the most potentially dangerous to the viability of the telephone counseling service. Second-hand clients are clients for whom someone else is making a call to the service. These calls range from boyfriends wanting the counselor to call the police, because he is afraid his girlfriend has taken an overdose of pills in her cross-town apartment to a mother wanting the counselor to personally check up on her student-daughter to make sure she is taking her medicine. The inherent difficulties and pitfalls in trying to or actually following up on these calls is obvious.

In the first example of the supposed suicide, an incident actually did take place where police were summoned and broke down the apartment door to find the surprised and frightened young lady reading a book. Incidents such as these can be extremely damaging to the reputation and credibility of a telephone counseling service.

A policy in these matters that I consider critical to follow is that the person on the other end of the phone and only that person is the client. In a practical sense, only his feelings, thoughts, actions, and problems can be dealt with. His interpretation of another's feelings, thoughts, actions, and predicaments are strictly his perceptions and may have no basis whatsoever in reality. In such cases, I always redirect the conversation to the client's feelings about what is occurring or what the client wants to do about the situation. Again, this forces responsibility back on the client.

OUTSIDE HELP AND TERMINATION. It is sometimes necessary but difficult for the counselor to introduce the idea that outside professional help is needed. Outside professional help may mean a therapist for the client at a clinic or hospital, or it may mean the introduction of a back-up senior staff person to take the phone for the counselor.

In the first instance, the counselor has determined that the client needs professional help on a continuing face-to-face basis, and he needs to introduce this idea to the client. In these cases, the following may be appropriate: *Others I have known with similar problems have gone for professional help. I wonder how you would feel about doing that?*

In the second instance, counselors occasionally run into the problem of feeling they are not getting through to the client or, in the case of suicidal clients, they wish to turn the phone over to someone with more experience. It seems generally appropriate for the counselor to share his feelings with the client and to be very open about his plans: *I am feeling frustrated, because I do not think we are getting anywhere. I wonder how you would feel about someone else taking over the phone?* If the client has no objections, the way is cleared. But if the client is, in effect, saying *No, I want you; you are getting through!*, it is wise for the counselor to stay on.

Second, terminating the call is just as important as any other facet of telephone counseling. For the client should leave the phone with the feeling that someone is interested in him and that he may call back if he has further troubles. I usually encourage clients to call back and let the service know how things have turned out, or if they need any further help.

Needless to say, not all telephone counselors will agree with everything I have said nor should they necessarily. However, the strategies and approaches outlined here have proven helpful in developing a consistent and rational approach to the problems of telephone counseling. ■

You cannot see my scars,
But they are there, and real,
Cut as deeply as the gorges
Sliced by a raging river
Rushing toward a hostile sea.

I drift in this bottomless ocean,
Searching for a friendly shore
Upon which I might find pause
From my lonely and constant fear
Of slipping away from life.

You pass like a ship at night
Seeing no distress, hearing nothing,
While my often whispered scream
Rises and signals as a silent flare
Casting its light as darkness.

I feel the waters closing now,
Covering all there ever was.
I feel the numbness coming now,
Blanking whatever will be.
I feel the waters closing now.

But wait,
I see a light!
A figure on the land
Throwing a hope out to sea
Offering a helping hand.

Bill Perry, Jr.

NATIONAL ASSOCIATION FOR MENTAL HEALTH

CITIZENS MAKIN

DECEMBER 1973

Victory in our impoundment suit to force release of $126 million for research, alcohol, and manpower programs

Amendment of the Health Maintenance Organization Bill to include our proposals for basic mental health coverage

JANUARY

1973 campaign total hits $14½ million

Network showing of "The Fragile Mind"

President-elect Gerridee Wheeler nominated as Ladies Home Journal Woman of the Year

FEBRUARY

Buzz Aldrin film and spots released

NAMH Conference on Critical Issues Related to Mental Health Research

Full Board of Directors on Capitol Hill to argue for our 1974 public affairs program

JUNE

Staff Institute

Full Board makes mid-year contacts on Capitol Hill

Association's proposal for bi-lingual services in community mental health centers (CMHC) added to both the Senate and House renewal bills

JULY

Unity and Standards report completed

National Institute of Mental Health (NIMH) budget increased by House

Education Act passed, including funds for states to initiate programs for mentally ill children

AUGUST

House approves CMHC renewal bill

"Journey" receives Atlanta Film Festival Award

Erik Erikson selected for Research Achievement Award

NIMH budget increased by Senate

G A DIFFERENCE  1974

MARCH	APRIL	MAY
United Way of America gives Association highest endorsement	*U.S. Civil Service finally agrees to delete routine employment question on prior treatment for "nervous breakdown"*	*Mental Health Month*
Rehabilitation Act amended to mandate affirmative hiring practices, including the "mentally handicapped"	*Autism included among disorders covered by developmental disabilities legislation*	*First NAMH research fellowships awarded*
		Victory in the Long Beach Suit to lift zoning restrictions

SEPTEMBER	OCTOBER	NOVEMBER
Senate approves CMHC renewal bill	*Percy Knauth accepts appointment as 1975 Mental Health Chairman*	*"Journey" receives Golden Eagle CINE Award*
Book, MENTAL HEALTH PROGRAMS FOR PRESCHOOL CHILDREN, published	*Book, PSYCHIATRIC TREATMENT IN THE COMMUNITY, published*	*1974 Annual Meeting and Mental Health Assembly—November 20-23, Washington, D.C.*
Department of Labor issues order to all institutions to comply with our successful antipeonage suit	*"Journey" receives Columbus Film Festival Award*	

By James K. Whittaker, Ph.D.

MENTAL HEALTH

DILEMMAS IN THE AGE OF AN ECOLOGICAL CRISIS

The best of times and the worst of times. Dickens' description of times long past aptly describes the dilemmas facing today's mental health practitioner.

Two movements, in particular, have helped to create these dilemmas. One is the increasing popularity of large scale macro-interventions directed at changes within organizations and communities; the other, growing concern with environmental protection and ecology.

Within the field of mental health, with its long history of providing help to those in need when they need it, the notion of moving from an individual case orientation to a more community or institutionally focused form of intervention is a discomforting one.

Even more basic than this are the seeds of a far-reaching conflict that appears to be emerging between environmental protection on the one hand and remedial programs on the other. If the former controversy between micro- and macro-intervention for purposes of human betterment is now only in its nascent phase, this latter conflict between the forces of conservation and those of remediation is still in embryo.

Taken together, these two sets of conflict between individual remediation and large scale community or societal intervention and between social treatment concerns and environmental concerns will hopefully produce in the future a rethinking and reordering of priorities based on a single value framework that extends from the broadest planetary concerns to the narrowest of individual problems. This rapprochement would appear to be light years away, however, and for the present there exists for the professional helping person a series of dilemmas that strike at the core of what he is supposed to be about: helping individuals, families and small groups to help themselves. Here are some of the particular problems and pitfalls faced by the professional helper:

The first dilemma for the helping professional has already been alluded to: How does one continue to justify any form of treatment or remediation, when the very physical environment is rapidly being destroyed around us and when what we so clearly need are massive programs of conservation and prevention? Put more simply: Aren't any efforts directed toward remediation just futile attempts to apply band-aids when what is needed is major surgery? Or to use another analogy: Aren't we really just serving to ameliorate the symptoms of human misery, while leaving the root causes

Dr. Whittaker is Associate Professor, University of Washington School of Social Work.

untouched? This latter argument appeals greatly to some social activists who view the sickness or problem as societal and not individual. They would change efforts directed not at individuals and families, but at the unjust and inadequate social systems that impact upon those individuals.

Beyond this hue and cry for less individual treatment and more community treatment or social action is heard the even louder clarion call of the environmentalists. Enhanced social welfare and amelioration of human misery, they would argue, simply cannot be based any longer on the notion of an infinitely ex-

panding technology and economy that will provide for whatever measures of improved social welfare are deemed desirable. The notion of more and more people sharing in the good life and being better covered in basic areas of health, education and welfare may, in fact, produce such a drain on renewable and non-renewable resources that the planet would suffer irreparable harm.

Thus, social reform measures must no longer be predicated on the concept of a cornucopia of resources awaiting only the guided hand of the social reformer to direct its boundless contents onto a greater multitude, but rather on K. Boulding's notion of the *spaceship earth* with its limited amount of life's basic resources that once depleted are gone forever. Finally, at least implicit in the argument of the ecologically concerned, is the judgment that certain problems such as overpopulation and the rape of the environment are so pressing, so ubiquitous and so much at the root of all other human problems, that they are deserving of the uppermost priority in the hierarchy of concern and should command the major share of resources.

Hence, the professional interested in interpersonal helping finds himself in a kind of *no-man's land* between those who argue for more social action and large scale system intervention on the one hand and those who cry for an even more basic attack on society's present collision course with the physical environment on the other.

A second dilemma lies in the potential clash of professional values with those set forth by the ecological movement. For example, in supporting the notion of a limited family size, perhaps enforced by government sanction, is not the professional compromising the basic principle of the client's right to self-determination? What is a moot point in the abstract becomes an increasingly uncomfortable reality for those professionals charged with counseling clients in the area of family planning. Some ecologically minded would argue that it is not simply a question of individual freedom to have as many children as one can care for adequately, but that the ability of society to absorb the increasing number of children, each taxing the already dwindling supply of non-renewable resources, should be the primary factor in the decision.

At what point, then, should the *rights* of society supersede those of the individual? In the near future the helping professional may be faced with a situation where he must choose between the individual client's right to self-determination in matters of family size on the one hand and supporting a policy of limitation that may be ecologically sound but infringes upon individual rights on the other.

The issue of population control is one that will shortly have to be faced by every helping professional, for it appears almost without exception as one of the major concerns of the ecological movement.

In this respect, one wonders what arguments, what rationale will be available to those who find themselves at the precarious point of contact between the disenfranchised seeking to grow in strength and numbers and those who would seek to limit population or preach restraint in the profit system? In a delicate and infinitely complex area of controversy, the question for the mental health practitioner may be simply reduced to: Whose side are you on?

For the individual professional and national associations like NAMH and the AOA, a related dilemma concerns the norms and guidelines to be used in planning interventive strategies. A step in the direction of short term gain may, for reasons already alluded to, prove ecologically unsound in the long run. On the other hand, even if one accepts the rightness of working on underlying disease processes such as overpopulation, how are we to deal with the victims of the multitude of other problems that beset society: poverty, racism, inferior education, mental illness, and others?

Even further assuming some consensus on the hierarchy of problems confronting us, at what level should they be attacked? Given limited manpower and financial resources, should greater attention be paid to the young or those who have suffered longer under the weight or social problems? What might have been armchair discussion even a few years ago now becomes daily reality for the helping professional faced with the problem of where to direct already scant resources and plagued with the underlying fear that what he can do will have virtually no effect anyway.

Another problem for the practitioner concerns his locus of practice: How does one continue to

continued

work within the system—in this instance, the mental health system—when the most serious pathology often does not lie within individual clients, but within the very service network of which the professional is a part? Can one still retain professional integrity and uphold a primary allegiance to clients in a bureaucracy that may, at times, dehumanize clients or base priorities on organizational expediency rather than on the basis of client needs? In short, when the helping professional becomes a part of the mental health establishment, does he not run the risk of placing allegiance to the organization before allegiance to clients?

Clearly, each profession's code of ethics would speak forcefully against this type of compromise in principle. But the question here is not really one of intent. The issue is whether or not segments of our mental health and social welfare system have gotten so large, so unwieldy and so diverted from their original purposes, that professional practice within them almost automatically runs the risk of becoming organization-centered rather than client-centered.

Assuming for a moment that this were a reality, even for a single mental health setting, what should the professional do regarding practice within that system? To work within the system would almost certainly mean that some professional values would be compromised, if only in the sense that the practitioner would have to cooperate in some degree with the policies and practices of the system. This latter course may prove to be particularly frustrating. For if his views are alien to the system and his values too outspoken, the professional may be asked to leave, thus depriving his clients of a much-needed service. On the other hand, too cautious a position, vis-à-vis internal change, will undoubtedly bring the professional into conflict with his own value system and code of ethics.

Another alternative for the helping professional would be simply to refuse to work within a system that engages in dehumanizing practices toward clients or places organizational needs before client needs. He could always choose to practice his profession elsewhere, but again his clients may be deprived of much needed services. Professional ethics would be upheld, but at what cost?

The situation is further clouded by the fact that issues and problems such as these are seldom clear-cut. For instance, who is to determine when an organization is serving its own needs at the expense of clients and by what criteria will such a decision be reached? Perhaps the organization even acknowledges unfair policies and inadequate practices, and invites the practitioner to join forces in bringing about needed changes. The nagging question becomes: *How effective will my change efforts be once I've become a part of that which I seek to change?*

A related dilemma concerns the degree to which the notion of a *target philosophy* is still viable in professional practice. Until recently it was sufficient for the helping professional to justify his practice in terms of working on a *piece* in the overall web of social problems. Given his limited scope and insufficient resources, he would aim for a specific target: working with emotionally disturbed children; counseling families; or treating the mentally ill. Presumably, enough *pieces* were receiving professional attention to suggest that the problem as a whole was being addressed.

But how valid is this concept of target philosophy today? Have not so many of the social problems we face been shown to be interrelated? Are not all of our social institutions in need of a basic and total restructuring? Can the mental health practitioner continue to be content with the knowledge that he is working on a part of the problem, if he truly believes that basic structural changes in the delivery of helping services are called for? Might it not be better to work toward the realization of those changes in lieu of offering direct services to a select group of clients? Finally, if the professional continues to work toward his specific target, believing as he does that basic systemic changes in the social welfare system are needed, is he not contributing to the illusion that the overall problem is really being met through a multitude of individual efforts?

A final dilemma of the helping professional concerns his commitment to social action. Given the maze of problems besetting our service delivery system and the particular dilemmas faced by the practitioner operating within that system, is it any longer possible to separate social and political concerns from professional life? There has been traditional support for the position that helping professionals should be committed to social action, but this has usually been translated to mean working through the social action arm of the professional organization or some similar group. In short, social action was fine, if it occurred after professional responsibilities to clients had been discharged.

But what if now the professional defines at least some of those responsibilities as requiring political and/or social action on behalf of his clients? Can he incorporate such activities into his professional helping role, especially when they may bring him into conflict with his agency or with the community? With rapidly changing definitions of service, the problem of deciding when to cease working with the client in a direct treatment relationship and to begin working on his behalf in an advocacy relationship is extremely difficult for the professional to answer.

Finally, what of the professional who views his responsibilities as lying only within the context of his direct treatment relationship with the client? He eschews the path of social or political action on behalf of clients and practices what he knows best—individual treatment. Increasingly, the question becomes: Can one be a professional helping person and remain apolitical?

While it is clear that justification for any form of remediation or interpersonal helping has come under intense criticism in recent times, it

is equally clear that much of the criticism would have us jettison the whole due to malfunctions in some of the parts. It is undoubtedly true that radical changes in our social welfare and mental health systems are needed, and that these changes will require a concerted effort at social action on the part of professionals and nonprofessionals alike. Further, it appears evident that efforts at individual treatment have not brought about these needed changes and, in fact, have contributed at least partially to the problem by attemping to help individuals adjust to essentially pathological social conditions. Finally, in a certain sense, the entire remedial field can be accused of merely ministering to the symptoms of the problem while leaving the root causes untouched.

What is easy to argue in the abstract, however, becomes more difficult to defend in the specific. Who will presume to deny help to the family in a state of emotional crisis, to the juvenile offender frustrated in his attempts to cope with the world around him, or to the lonely young adult who is terrified of social relationships yet longs for warmth and acceptance? On what grounds will help, however inadequate, be denied to these individuals? Without question, the provision of temporary remediation to these symptoms will not solve the basic problems of family disorganization, poverty, inferior education and anomie that underlie the specific manifestations. But in carrying forward the banner of social reform, can we ignore completely those who have already felt some pain?

At another level, even given the most enlightened and progressive social institutions, it is naive to assume that the society will be free of all individuals requiring treatment or remedial help. Too often social activists fall into the trap of explaining all individual problems as socially determined, i.e., simply modify the environment and the problem will disappear. Suffice it to say, this kind of logic blunts individual differences and underplays the function of organism in the paradigm: stimulus-organism-response. Finally, who can predict that new social institutions will not create new problems of adjustment requiring new forms of remediation?

The solution to this first dilemma would appear to lie in a more socially conscious and informed helping professional, linking his remedial efforts with those of the social activist directed at more basic reforms. Exactly how this rapprochement comes about is, of course, the nexus of the dilemma. But difficult as this *both/and* approach may be to implement, it is far more desirable than the simplistic *either/or* view

which holds that improved social conditions will do away with the need for all remedial helping, or that individual treatment is all that is needed to solve society's problems. The major difficulty occurs when we mistakenly ascribe the goals of one to the other, i.e., interpersonal helping or treatment will not of itself bring about needed reform in our social institutions, nor will improvements in those social institutions do away completely with the need for remedial efforts.

In the past two decades the technology of treatment—the various treatment modalities and strategies and techniques of individual change—have undergone considerable modification and have emerged

continued

SIMPLY MODIFYING THE ENVIRONMENT WILL NOT MAKE ALL INDIVIDUAL PROBLEMS DISAPPEAR

greatly strengthened and refined. Perhaps it is now time to turn with equal vigor and resolve to a careful examination of the values underlying that technology. In light of what many feel to be the impending spectre of the environmental crisis, it would be well to re-examine our long-held belief in the individual's right to selfdetermination and see how this articulates with the needs and demands of an increasingly complex and more densely populated society. On a broader scale, the value base that underlies social welfare generally must be reexamined.

As far as working within the system, two separate circumstances would seem to prevail. In the first, the system may have simply reached the point where the sheer number of clients to be served, arbitrary or capricious policies, dehumanizing practices or a combination thereof, have made it virtually impossible for professional services to be rendered. In such cases, it seems that the only proper course of action for the professional would be to leave and do all in his power to lead or support efforts to see that such policies or practices were eliminated. In the second instance, where some dehumanization exists along with acceptable practice, the professional should move to expose such practices and seek remedies through advocacy action on behalf of the clients involved.

Clearly, such a commitment to client advocacy, which is required by the professional's code of ethics, presupposes a strong and viable machinery within professional associations to support and investigate such advocacy actions and provide legal assisttance to professionals who may be putting their positions on the line.

The issues posed by the question of target philosophy do not readily yield solutions. It is, of course, true that in addressing ourselves to specific targets, the overall problem may be neglected. In addition, there is some justification to the notion that in operating on specific target populations, helping professionals have perhaps inadvertantly supported the mistaken notion that more basic underlying societal problems were being addressed. On the other hand, it would appear equally correct to say that in addressing any problem one necessarily has to speak about specific targets for change. Otherwise, we run the risk of getting caught up in the effervescence of the rhetoric of reform without ever having addressed the question of planful change.

It appears evident that what we do not need are more narrowly focused clinicians who have no awareness or apparent interest in their clients outside of the weekly treatment encounter. We should shun with equal resolve those who speak loudly of the needs for more basic societal changes, but whose fascination with their own rhetoric precludes their ability to discuss specific means to specific ends.

STRONG, VIABLE MACHINERY WITHIN PROFESSIONAL ASSOCIATIONS IS REQUIRED FOR CLIENT ADVOCACY

The notion of a target philosophy is still valid, but what needs revising are the definitions of the targets. Specifically, do many of our existing problem categories make sense anymore in light of what we now know about the interrelatedness of social problems? Do the categories "dependent," "neglected," "delinquent," "mentally ill" or "socially maladjusted" continue to make sense and, if not, what better ways are there of defining the problem? Each of these existing problem categories comes complete with its own network of helping services designed to remediate that particular problem.

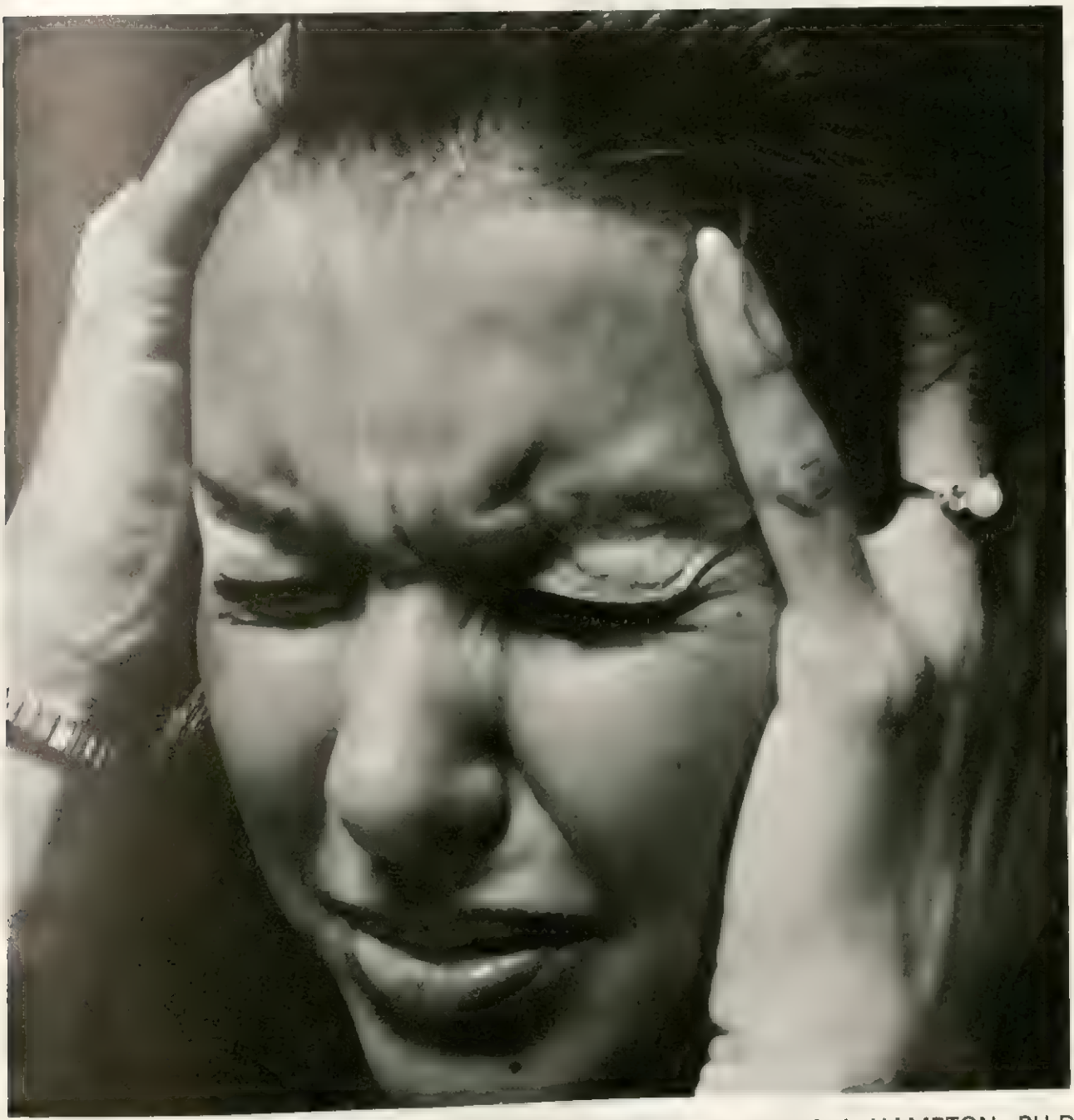
But times and problems change, perhaps not as quickly as our perceptions of them, and this is all the more reason to give a long and hard look at our present system of defining problems and to see how well that system fits with the reality of the current situation. If the present way in which we go about defining problems is based on false assumptions or outmoded analyses, then perhaps the very categories themselves should become targets for change.

There are, of course, some potential pitfalls in the adoption of advocacy stances by professional helping persons. Promotion of one client's interest might be at the expense of another, as in the case of scarce resources, and all of the problems concerning the legal sanctions available to the worker who initiates an advocacy action as well as those which may be potentially used against him have not been fully explored.

Despite the problems in setting up the machinery for advocacy actions—and this would appear to be the crucial factor—it is clear that a narrowly focused treatment agent interested only in his client's emotional state and unmindful of the social conditions that impact upon that client is as out of place with the realities of the time as he is in basic disagreement with his professional code of ethics.

In facing these multiple dilemmas, the professional helping person may find that the value system he has been operating on no longer matches the real life situations he faces and is as little help in actually solving problems. What this suggests is that the helping professions will have to come full circle and view themselves as the targets for much needed change. Such a mandate is clearly staggering in its implications and will require of all professionals the deepest of soul searching and the most wrenching kinds of change. ■

TRAGEDY EXAMINED



A THOUGHT-PROVOKING LOOK AT WHY WE LIKE IT. BY PETER J. HAMPTON, PH.D.

TRAGEDIES HAVE FASCINATED throughout recorded history. Some of the greatest writings ever have been tragedies—Euripides' *Electra*, Sophocles' *Antigone*, Shakespeare's *Hamlet*, Goethe's *Faust*, O'Neil's *Desire Under the Elms*. Tragedies mark man's aspirations and activities as he plods along from century to century. Alexander the Great, Attila the Hun, Napoleon; and, in more recent times, Hitler, Mussolini, and Stalin have been arbiters of great human tragedies. In our own day, such names as Viet Nam, Nigeria, and East Pakistan attest to the fact that tragedies are not limited to a given age. Tragedies pervade the world of ideas, the world of people, and the world of things at all times.

TRAGEDY AND ANGER

If tragedies, then, are indeed continuous, is it possible to stamp them out? Probably not. Tragedy, when not the result of Providence, seems to be the result of man's foolish mistakes, mismanagement, and desire to destroy. Anger, the substance of tragedy, is natural. In a competitive world, where every person has to strive to secure a place in the sun, and then strive even more to retain this place in competition with others, anger—leading to destruction, leading to tragedy—remains a natural phenomenon. But it does not have to remain quite so natural if we can channel it into constructive activities. In this way, tragedy can burn itself out without doing harm to the self, to others, or to the world we live in.

TRAGEDY AS THERAPY

The greatest service that tragedy can render is to permit the release of tension and thus assuage frustration. In this sense, tragedies can be a boon to the person who uses them to still the pain of his or her discomfort and unhappiness. Tragedies thus become cathartic in their fulfillment. This realization is not new. Aristotle, in his *Poetics*, points to tragedies as being healing in nature. So do many others who consider tragedy a way of life.

Recently, we asked a random sample of young people why they like tragedies. Time and again, they pointed to the use of tragedy as a therapeutic salvation, which permits the ventilation of feelings, the projection of undesirable traits, and the introjection of desirable characteristics.

TRAGEDY AND TOGETHERNESS

Many of us live in crowded isolation. We work in the same offices and factories; we shop at the same stores; we save at the same banks; and we vacation at the same resorts. And yet, we know so little about each other. Then tragedy strikes! It may be nature on a rampage—in a hurricane, an earthquake, a devastating fire or flood. It may be man at his worst—in a civil war, in rape and murder, in moral degradation. The results? We feel closer to each other. We find security in togetherness, a togetherness that comes when we experience each other as persons and not just as another worker, another customer, another tourist.

The college students we talked to about tragedy are keenly aware of the need for meaningful togetherness—more so than adults or children. Perhaps this is because teenagers, in particular, find themselves in an in-between period, when they are no longer children and not as yet legal adults, and so depend more heavily upon peer relationships. It is during this storm and stress period when tragedy as a bond-producing experience means so much to young people. It is the need for togetherness that, in large measure, explains both the sadism of youth's protests and the masochism of youth's drug addictions.

TRAGEDY AND TRUTH

We also find that people like tragedies because they are tired of fairy tales and misrepresentations. They want to experience things as they really are, not as the politicians say they will be, as the philosophers say they could be, or as the moralists say they should be.

For instance, there is no way of camouflaging the death of 10,000 Pakistanies who died at the hands of a typhoon; there is no way of hiding the injuries sustained by thousands of persons in the daily automobile carnage that we live with; there is no way of pretending that the smog that precedes us when we drive into any large city is not there. Tragedy has a way of being true to its cause and to its results, and thus, it occasionally seems to be a welcome antidote to the delusions and deceptions that confront us in life.

TRAGEDY AS A WEAPON

There are those who use tragedy as a weapon of retribution or revenge. When we examine people in depth to see with what emotion they lead in their behavior, we find that many persons lead with anger. These are the impatient, annoyed, critical, hostile, belligerent people who have, over a period of time, generated so much in the way of repressed hostility that they no longer can control their impulses to hurt, to damage, to destroy. Such people live on tragedies. They derive pleasure from other people's misfortunes.

Anger obviously plays a part in every person's life. Most of us, however, try to dilute anger as it builds. We redirect it through sublimation, compensation, or substitution. We develop the necessary negative adaptation and frustration tolerance to deal with anger. We also establish opportunities for tension reduction by channeling uninvited hostilities into constructive ways of acting, such as frequently found in occupational and avocational activities.

Thus, the bacteriologist may relieve his anger by combating bacteria, or the educator by battling ignorance. Bowling or golf can present similar opportunities for redirecting anger. It is only when hostility is used as a means to destructive behavior, or is belittling and defaming of another person's ego, that we must put a halt to it.

TRAGEDY AS EDUCATION

So often in life we learn only when we are forced to learn. We do not learn as much as we should from past experiences. However, when we are shocked by tragedy into a realization that we have done wrong, that we have been mistaken, that we have been blind to our shortcomings, we learn quickly. Tragedy makes us do so.

For instance, a person may go on with his job for months, even years, failing to live up to his contractual responsibilities, continuing to shortchange himself and his employer. Then tragedy strikes! He is laid off; he may be asked to resign; he is fired. Frequently, only when such a calamity befalls man is he willing to change his ways.

There are other reasons why we like tragedies, many of them probably, but the reasons discussed appear to be the most important for young people. They have a great need for therapeutic self-expression. They also place great store upon togetherness. Young people are idealists and so find that truth is very important to them. Occasionally, they find that they have to fight back, because the establishment doesn't attend to them nor appreciate them, so tragedy as a weapon becomes important. And, of course, since young people are only on the threshhold of life, they find that tragedy is of great value, because it can teach them the lessons of life they need to learn to make the most of themselves and their opportunities. ■

Dr. Hampton is Director, Department of Developmental Programs, the University of Akron, Akron, Ohio.

BOOKS

Gene Usdin, M.D.

The International Pilot Study of Schizophrenia, Volume 1

Geneva: World Health Organization, 1973. 427 pp., $19.60. English edition only.

It is hard to decide where to begin in reviewing a work such as this, for it is highly technical and focuses on the methodology used in this international study. The sub-title of Volume 1 indicates that it contains the *results of the initial evaluation phase.* The second volume, not yet published, is to report 1- and 2-year follow-up studies of the patients described herein.

The organization of his international study began 6 years ago, and the first patient was examined 4 years ago. The collaborating centers were located in Denmark, India, Colombia, Nigeria, the United Kingdom, the Soviet Union, China (province of Taiwan), Czechoslovakia, and the United States.

Allegations have been made in the past that diagnostic criteria and cultural differences are so great among the countries of the world that agreement on the diagnostic criteria of schizophrenia is virtually impossible. It was the general aim of this pilot study to examine this opinion, as well as related questions. This was not an epidemiologic study of the incidence or prevalence of schizophrenia. Rather, it attempted to do the much-needed groundwork that must precede investigation of schizophrenia's natural course.

There is not space in this review to do justice to the findings of such a well-organized and high-caliber investigation. Suffice it to say that the results indicate that it is possible to identify a group of schizophrenic patients having a distinctive pattern of symptoms, that this pattern is consistent between the nine collaborating centers, and that there are patients belonging to this group in every center of the study.

Furthermore, this group of patients can be identified by any one of three different methods of data analysis. It also showed that it was possible to train psychiatrists in developing, as well as developed, countries to act as principal investigators in this type of project. In fact, the level of cooperation that must have existed between the members of this group indicates their willingness to set aside vested interests.

This volume should certainly be in every medical and psychiatric library and should be in the personal libraries of investigators of psychiatric disorders who are interested in designing their studies on very firm grounds. The technical methodology is described lucidly and would be stimulating to most investigators.

R. DEAN CODDINGTON, M.D.
Professor of Psychiatry
Louisiana State University Medical School
New Orleans, La. 70112

Psychopathology: Contributions From the Social, Behavioral and Biological Studies

Edited by Muriel Hammer, Ph.D., Kurt Salzinger, Ph.D., and Samuel Sutton, Ph.D.
New York: Wiley-Interscience, 1973, $18.95.

The name of Joseph Zubin, Ph.D., of Columbia University and the Biometrics Research Unit of the New York State Department of Mental Hygiene have been synonymous with high quality research and theory in the broad field of psychopathology for almost three decades.

The present book contains 29 chapters by his former students and professional colleagues and, together, these chapters constitute a very useful reference source primarily for the professional. However, the layperson interested in a special topic (e.g. contributions from the social, behavioral and biological sciences to our knowledge of schizophrenia, biofeedback research; and ethnic groups and psychiatric disorders) will find much of interest in this volume.

Chapters by such well-known scientists as Neil Miller, Lissy and Murry Jarvik, Barbara and Bruce Dohrenwend, Sarnoff Mednick, Howard Hunt, Paul Lazarsfeld and Anatol Rapoport, to mention just a few of the greats represented in this collection, make it a remarkable tribute to a remarkable teacher, scientist, colleague, and friend.

JOSEPH D. MATARAZZO, PH.D.
Chairman, Department of Medical Psychology
University of Oregon Medical School
Portland, Ore. 97201

Change
Paul Watzlawick, John Weakland and Richard Fisch
New York: Norton and Company, Inc., 1974. 172 pp., $7.95.

The message of *Change: Principles of Problem Formation and Problem Resolution* is as general as the title indicates. The authors study the mechanism of change from a wide perspective. They focus particularly on paradox, the failure of *reasonable* solutions, and the success of seemingly illogical alternatives.

The structure of the study is taken from mathematics: the theory of logical types and group (set) theory. First-order change is simple linear change. Second-order change is change of change, which classical, Aristotelean thought ignores. Paradox arises from a shift of contextual levels: second-order change. *Unreasonable* solutions often succeed by an analogous shift. Problems are created by attempting first-order change where second-order change is necessary and *vice versa.*

Although the model is intended to be applied to any field, the authors demonstrate its applications in psychotherapy. After rejecting nearly every other form of treatment, very limited solutions are offered in their stead. They claim a 40 percent success rate in meeting pre-determined specific goals, e.g., persuading a recalcitrant adolescent to study, with an average of 7 hours of therapy. Follow-ups were made 3 to 6 months later; longer-term results would have been significant, since a deeper investigation of motivations and emotions of the patient is rejected (almost ridiculed!). While the authors are cautious about claiming *cures*, attempts to find more extensive solutions to patients' problems are implied to be unscientific: second-order solutions to first-order problems.

Much of the therapy illustrated utilizes manipulation of the patient. The authors justify this by asserting that the therapist cannot avoid influencing a patient by his behavior and, therefore, his goal is to understand and use this influence. Their argument makes no distinction between influence that may allow cooperation between patient and therapist, and manipulative control. However, in many of the cases the manipulation seems fairly harmless, and applications of the model have intriguing potential as therapeutic tools.

Many examples and analogies help clarify the abstract material presented. The authors reflect a wide range of literary and psychiatric references, and they have succeeded in creating a model for problem formation and resolution with almost boundless applications.

W. ROBERT BEAVERS, M.D.
Timberlawn Foundation, Inc.
Dallas, Tex. 75227

Human Development
James Lugo and Gerald Hershey
New York: MacMillan Publishing Co., Inc., 1974. 581 pp., $9.95.

This basic text, using a multidisciplinary approach, provides a broad-based background for the study of human development. But more than that, it enlarges the student's own personal insight and encourages him toward further readings. The many diagrams, graphs, and tables make a vast amount of information readily available. Lugo and Hershey have organized the material through a modified systems approach into three main parts: *Multidisciplinary Perspectives, Life Goals,* and *The Life Cycle.*

The first of these three parts emphasizes the chief conceptual and methodological tools of the various disciplines and their application to the study of human development. After a brief history of the child in society, this section presents five overviews from various perspectives—philosophy, anthropology, sociology, biology, and psychology.The philosophical perspective presents five of the most influential positions and discusses their impact upon the thinking about children, families, and psychological development. Throughout, there is emphasis on a subjective, experiential understanding to give the student a sense of personal involvement with the material.

The part exploring Life Goals describes certain developmental goals within each of four major domains of the human condition—biologic, cognitive, affective,

and social. It then presents four models (Combs, Bonner, Rogers, and Matlow) of the more fully human person, and three views (psychoanalytic, behavioristic, and humanistic) of the process of becoming one.

The major body of the text is the Life Cycle. Now that the reader is subjectively involved with the material, he is presented with a chronological scheme of development. This scheme traces out each successive stage, using the four domains as guidelines. It is an amalgamation of much diverse material and avoids the staid jargon that so often seeps into such a work. There is ample research data presented, and the references and suggested readings are highlights of the book.

MARK J. BLOTCKY, M.D.
Department of Psychiatry
The University of Texas
Southwestern Medical School
Dallas, Tex.

From Instinct to Identity: The Development of Personality
Louis Breger
New Jersey: Prentice-Hall, Inc., 1974. 371 pp., $8.50.

When placed side-by-side on a platter, the taste and flavor of the best of delicacies become dilute. Louis Breger, has, however, managed to coordinate the findings of ethology, primate studies, anthropology, linguistics, psychology, child development, dream research, psychoanalysis, and more into an integrated menu of personality development from infancy through adolescence.

Using as primary ingredients the works of Freud, Erikson, and Piaget, he adds Lorenz, Harlow, and Lawick-Goodall, Levi-Strauss, then Bowlby and Laing and, finally, Loevinger and Kohlberg. It never becomes a stew; the flavor of each remains unique. He spices his developmental-evolutionary recipe with Peter Pan, Jack in the Beanstalk, Alex Portnoy, and Holden Caulfield. He sprinkles the top with delicious quotes from Vonnegut, La Rochefoucauld, Huckleberry Finn, and Bob Dylan.

In this filling smorgasbord, one never loses sight of Breger's personality, remarkable objectivity and fairness, which are present throughout his sense of taste.

From Instinct to Identity whets the appetite for further study. If it is reserved for undergraduate instruction in the selective area of personality alone, and not made available to those in allied fields, it will have been truly *wasted on the young.*

MICHAEL R. ZALES, M.D.
Edgewood Drive
Greenwich, Conn. 06830

Occupational Stress
Edited by Alan McLean, M.D.
Springfield, Ill.: Charles C. Thomas, 1974. 111 pp., $9.75.

This slim volume of papers and summaries of papers presented at the 1972 Occupational Mental Health Conference reflects the now well-established practice of publishing in book form the proceedings of a 2-day conference.

Eight of the twelve chapters of this book have been previously published in the same journal. In view of that easy availability, this reviewer wonders what purpose is served by this volume. Despite that set regarding this species, there are a number of excellent essays.

Levi's review of his group's work is a succinct statement of a number of years of investigation. Schwartz's chapter on the use of health data as one source of management information is instructive. McLean's concluding overview focusing on the difficulties engendered by disciplinary differences in conceptualizing stress seems pertinent and points the direction for subsequent conferences.

Whether the publication of the proceedings of subsequent conferences will be in the form of journal articles, a single volume, or both will be decided. This reviewer votes for one or the other, but not both.

JERRY M. LEWIS, M.D.
Director of Research and Training
Timberlawn Foundation, Inc.
Dallas, Tex. 75227

Psychiatry in Transition
Judd Marmor, M.D.
New York: Brunner/Mazel, Inc., 1974.
448 pp., $15.00.

This book consists of 32 papers by Marmor that were published separately over a 30-year period (1942-1972). If read from the first to the last, they convey a remarkable degree of coherence and unity, a procedure that this reviewer recommends in contrast to the more usual *cross-sectional* picking out of selected papers.

By reading the book as a whole, one can follow not only the transitions within psychiatry over those years, but also the concomitant and related sequence of the author's own transitions in his professional development. Furthermore, the early papers are still relevant. A certain amount of updating is achieved through footnotes. Although there is some repetition, this often proceeds in spiral form so that the idea, when repeated in a later paper, is further developed.

The volume is divided into four parts, which deal respectively with general psychiatry, psychoanalysis, psychotherapy and social psychiatry. The papers within each part are in chronological sequence. There is considerable overlapping of content between these parts that, in a sense, illustrates Marmor's capacity to integrate each of these four specialized areas into a unified and unifying sense of professional identity. Throughout the book, the author is concerned, one way or another, with two major themes: The complex working of individual and sociocultural factors upon each other, and processes of change, whether at the psychotherapeutic or societal levels. While adhering to what he refers to as the basic assumptions of psychoanalysis, Marmor regards the instinct theory as inaccurate. He also suggests changes in psychoanalytic training and technique and discusses how learning theory may apply to therapeutic change.

This book provides a scholarly, lucid, and candid account by a leader of American psychiatry today of what he thinks, how his lines of thought developed over the past 40 years, and the evidence and reasoning on which they are based. Because of the wide range of topics dealt with, the book should have broad readership appeal among professionals. For many, it will no doubt stir up stormy disagreement. For others, it will provide clarity and intellectual support. But reading it seems bound to force both critics and admirers to think more rigorously about central, pressing issues and dilemmas that confront psychoanalysis and psychiatry today.

Proposed changes in mental health service programming, delivery, and funding are in the process of national planning and debate. The need for hard critical thinking, such as Marmor's book makes one do, is crucial to the kinds of input and impact our various disciplines can make regarding these changes.

Furthermore, from the standpoint of shaping health policy, his approach has special value for counteracting the everpresent risks of one-sidedness and *either/or-ism*. This applies to the comprehensiveness and emphasis he places on field theory and dynamic integrative relationships, such as between individual and society, personality and culture, theory-formation, clinical practice and training, and psychodynamic principles and social issues.

For this reviewer, therefore, the areas of her disagreement with the author—and there are several—seem of less importance than her appreciation for the contribution that this book represents toward the hope of bringing about a sound and humane outcome to the psychiatric transition.

VIOLA W. BERNARD, M.D.
Columbia University
New York, N.Y. 10027

Cultural Pluralism in Education
Madelon D. Stent, William R. Hazard and Harry N. Rivlin
New York: Appleton-Century-Crofts, 1973.
167 pp., $7.95.

Despite the rather excellent information and instruction found in the papers submitted by Manuel Guerra and John Aragon, *Cultural Pluralism in Education* constitutes one more unfortunate and unnecessary publication that upholds the unsupport-

able premise that children learn, grow, develop, and succeed or fail within the milieu of the school alone, and remain clinically isolated from the dimensions of family, peer group, church, community, and economic status.

The book is a collection of position papers contributed largely by angry Chauvinists who have the temerity to carve out a variety of Balkanized educational enclaves within which they seem determined to confine the ethnics over whom they assume suzerainty.

I mindful of the challenges met and resolved by countless Southern Italians, Russian Jews, Irish Catholics, Asiatic and Near Eastern Immigrants who constituted an *unwanted* human resource in the Anglo Saxon, Protestant-oriented public school system of an earlier day, a significant number of the contributors to this book appear to find the Blacks, Puerto Ricans, Chicanos, and Indians to be composed of lesser quality, and unable to clear the educational hurdles unless specially nurtured within the bosom of ego-enhancing homogeneity begotten of ethnocentricity.

GEORGE E. FLANAGAN
Special Lecturer in Sociology
Louisiana State University
Baton Rouge, La.

Annual Progress in Child Psychiatry and Child Development
Edited by Stella Chess, M.D., and Alexander Thomas, M.D.
New York: Brunner/Mazel, Inc., 1973. 752 pp., $15.00.

This is the sixth volume of an annual series devoted to outstanding work in child psychiatry and development. It is a comprehensive collection of recent articles, findings, and systematic reviews. The volume contains 43 contributions covering a broad range of interests including infancy and development, parent-child separation, language and learning, racial identification, childhood psychosis, drug and outcome studies.

The infancy and developmental sections cover work from infancy to adolescence. They include a review and clarification of the concept of critical periods in infancy and a review of 50 contemporary cross-cultural studies of infant psychomotor development. An excellent outline of present knowledge about maternal deprivation describes various mothering experiences, psychological mechanisms, and the resultant syndromes. Convincing original work is offered relating malnourishment in the first 2 years of life to intellectual performance.

In separate articles, the concept of latency as a quiescent period and of adolescence as a crisis period are seriously questioned. An enlightening report on psychological aspects of kibbutz life is presented from over 15 years' experience with 3,000 emotionally disturbed children.

The important literature on language and learning is well represented by articles on the cognitive basis of language learning; the legitimacy of black lower socioeconomic class grammar; a transcultural study of dyslexia; and a concise review of malnutrition, learning and intelligence. New data relating to racial identification is well presented in three articles studying drawings, self-esteem and racial preference, and white adult behavior toward black and white children.

A tremendous amount of research has been done in the last 10 years on psychotic disturbances in childhood. Such interest is properly reflected in a well-organized and comprehensive, yet readable, review of recent developments in these disorders. A surprising study is presented that demonstrates the similarity of looking and approach behavior in autistic, schizophrenic, and normal controls.

As always, the editors of this annual have done an excellent job of reviewing the current child literature and organizing the most outstanding work. It is a highly recommended resource for every professional concerned with children.

MARK BLOTCKY, M.D.
Department of Psychiatry
Children's Psychiatric Clinic
The University of Texas
Health Science Center at Dallas
Dallas, Tex. 75201

To Die Is Not Enough
Donald Delano Wright
Boston: Houghton, Mifflin Company, 1974. 238 pp., $5.95.

This is the story of a man who committed two separate murders one Christmas Eve, and how the law dealt with him. The pattern of Don White's life is all too typical: a black child not only without a father for the most part, but also without a mother, brought up in a love-hate relationship with a foster mother (who may actually have been his grandmother). Here was a youngster, who had been repeatedly diagnosed as mentally unstable and dangerous. Wracked by overwhelming feelings of worthlessness, frustration and rage, he turned into a man of violence, with a record of continual delinquency, crime and imprisonment, that culminated in the double brutal murders.

The story of the legal proceedings that followed is also depressingly typical: the conviction and sentence of death, and then the long-drawn battle of attorneys to save him from the noose, with appeals, writs and proceedings in state and Federal courts, and requests for clemency. A few days before the scheduled execution, his conviction was overturned and a new trial ordered. At that trial, White was again found guilty but without the death penalty. After 9 years in confinement, 4½ of them on Death Row, he started to serve his sentence. Once again we see the inordinate amount of time that efforts to exact the death penalty costs society.

The most laudable part of the story is the unflagging persistence and dedication of his assigned counsel over the long years. No less noteworthy is the change that occurred in White. The loyalty and fellow feeling shown by counsel, and the sympathy of clergymen and of numerous correspondents, gradually turned this man of flaring violence into one who could appreciate friends, a reader of books, a convert to religion, and a painter of apparently some talent—a testimonial to the article of faith that there is worth, if we can but find it, in every person.

HENRY WEIHOFEN, J.S.D.
Professor of Law Emeritus
University of New Mexico
Albuquerque, N.M.

The New Sex Therapy
Helen Singer Kaplan, M.D., Ph.D.
New York: Brunner/Mazel, Inc., 1974. 544 pp., $17.50.

In this era of beautiful bodies, it is amazing how m[illegible] of them don't really function well. Although many [illegible] them appear to be sun-tanned and to eat and sleep well, other vital functions—such as the sexual, that are largely hidden from the purview of their neighbors—may be distressed.

Rarely does a reviewer have the opportunity to read 600 pages in his own field and find that the book both carries his interest and provides a clearer picture of something he deals with on a day-to-day basis. Without being pedantic, Dr. Kaplan has succeeded in making a major contribution to the academic as well as the clinical literature associated with psychiatry.

The book is extremely well-organized and may be approached in its entirety or in segmental reading and reference, its basic objectives are well-defined, and the printing is clear.

One of the most important points made is that sexual problems do not always have to be approached in extreme depth or for a great deal of time in order to achieve results. The author states that *sometimes this intervention in the crisis is sufficient in itself to help the patient regain his equilibrium. At other times, rapid resolution of immediate conflicts merely prepares for work with the deeper issues which are in dynamic interplay with the surface problems.*

I think this succinctly describes her approach to the fact that while function may proceed without a full understanding of what is actually occurring, *the experiences of sex therapy reinforce and underscore the importance of unconscious motivation in the genesis of problems, and for that matter in all human behavior.*

I highly recommend *The New Sex Therapy* for any clinician involved in the treatment of patients whether or not this is the presenting disorder.

BURTON C. EINSPRUCH, M.D.
Timberlawn Hospital
Dallas, Tex. 75227

PUBLICATIONS

To order, write NAMH Publications Dept., 1800 No. Kent. St., Arlington, Va. 22209

Policy and Position Statements (*Free on request*)

☐ ABORTION
☐ AMERICAN SCHIZOPHRENIA FOUNDATION
☐ CHILD DEVELOPMENT CENTERS
☐ CIVIL RIGHTS OF MENTAL PATIENTS
☐ THE DISADVANTAGED
☐ FACILITIES AND SERVICES FOR THE GERIATRIC MENTAL PATIENT
☐ FAMILY LIFE AND SEX EDUCATION
☐ HOMOSEXUALITY
☐ HUMAN EXPERIMENTATION
☐ JOINT COMMISSION ON MENTAL HEALTH OF CHILDREN REPORT
☐ JOINT COMMISSION ON MENTAL ILLNESS AND MENTAL HEALTH
☐ MANPOWER
☐ MARIJUANA
☐ MARRIAGE COUNSELORS
☐ MENTAL HEALTH PROGRAM WITHIN THE ORGANIZATIONAL STRUCTURE OF STATE GOVERNMENT
☐ MENTAL HOSPITAL/LABOR-MANAGEMENT DISPUTES
☐ MENTALLY ILL AND THE LAW
☐ NATIONAL HEALTH INSURANCE
☐ PASTORAL COUNSELING
☐ PSYCHIATRIC AIDE
☐ PSYCHOSURGERY
☐ RIGHT TO TREATMENT
☐ STANDARDS FOR LABOR PERFORMED BY STATE HOSPITAL MENTAL PATIENTS
☐ SUICIDE PREVENTION
☐ THIRD PARTY PAYMENTS FOR THERAPISTS

Pamphlets

☐ CHILD ALONE IN NEED OF HELP. $2.30 per C.
☐ CLERGYMAN'S GUIDE TO RECOGNIZING SERIOUS MENTAL ILLNESS. $10.00 per C.
☐ MINISTERING TO FAMILIES OF THE MENTALLY ILL. $10.00 per C.
☐ THE CLERGY AND MENTAL HEALTH. $10.00 per C.
☐ FACTS ABOUT MENTAL ILLNESS. $1.50 per C. Basic up-to-date statistics.
☐ FILM CATALOG. Free. Selected films for mental health education.
☐ GROWING UP AIN'T THAT EASY. $1.20 per C. Dos and Don'ts for dealing with the emotionally disturbed.
☐ HOW TO DEAL WITH YOUR TENSIONS. $7.50 per C.
☐ HOW TO INVOLVE ETHNIC MINORITIES AND THE POOR IN THE MENTAL HEALTH ASSOCIATION. $12.50 per C.
☐ HIGH COST OF MENTAL ILLNESS. $2.30 per C.
☐ HOW TO DEAL WITH MENTAL PROBLEMS. $7.50 per C.
☐ HOW TO RECOGNIZE AND HANDLE ABNORMAL PEOPLE: A MANUAL FOR POLICE OFFICERS. $1.15 each or $90 per C.
☐ MENTAL ILLNESS CAN BE PREVENTED $2.20 per C.
☐ MENTAL ILLNESS: A GUIDE FOR THE FAMILY (revised edition). 80¢ each. Handbook for families of the mentally ill.
☐ NAMH PUBLICATIONS CATALOG. Free.
☐ SOME THINGS YOU SHOULD KNOW ABOUT MENTAL AND EMOTIONAL ILLNESS. $2.00 per C; $16.35 per M.
☐ WHAT EVERY CHILD NEEDS FOR GOOD MENTAL HEALTH. $1.35 per M.
☐ WHEN THINGS GO WRONG. $9.00 per C.
☐ THIS IS YOUR MENTAL HEALTH ASSOCIATION. $3.00 per C.
☐ WHERE YOU CAN FIND INFORMATION ON MENTAL HEALTH AND MENTAL ILLNESS: A BIBLIOGRAPHY. $1.50 per C.

Joint Information Service Publications

☐ CHILDREN AND MENTAL HEALTH CENTERS. $6.00 each.
☐ ELEVEN INDICES. $4.00 each.
☐ HALFWAY HOUSES FOR THE MENTALLY ILL. $6.00 each.
☐ MENTAL HEALTH ON THE CAMPUS: A FIELD REPORT. $7.50 each.
☐ HEALTH INSURANCE FOR MENTAL ILLNESS. $2.50 each.
☐ LEGAL SERVICES AND COMMUNITY MENTAL HEALTH CENTERS. Henry Weihofen. $2.00 each.
☐ MENTAL HEALTH PROGRAMS FOR PRE-SCHOOL CHILDREN. $7.00 each.
☐ PARTIAL HOSPITALIZATION FOR THE MENTALLY ILL: A STUDY OF PROGRAMS AND PROBLEMS. Cloth: $6.00 each; 4 or more copies $5.25 each. Paper: $4.00 each; 4 or more copies $3.50.
☐ PRIVATE PSYCHIATRIC HOSPITALS: A NATIONAL SURVEY. $3.00 each.
☐ PSYCHIATRIC TREATMENT IN THE COMMUNITY $3.50.
☐ REHABILITATING THE MENTALLY ILL IN THE COMMUNITY. $6.00 each.
☐ SALARY RANGES OF PERSONNEL EMPLOYED IN STATE MENTAL HOSPITALS AND COMMUNITY MENTAL HEALTH CENTERS, 1970. Patricia L. Scheidemandel and Charles K. Kanno. $4.00 each.
☐ THE COMMUNITY MENTAL HEALTH CENTER: AN INTERIM APPRAISAL. Cloth: $6.50 each; 4 or more copies $5.25 each. Paper: $4.00 each; 4 or more copies $3.50.
☐ THE MENTALLY ILL OFFENDER: A SURVEY OF TREATMENT PROGRAMS. Patricia K. Scheidemandel and Charles K. Kanno. $2.00 each.
☐ THE PSYCHIATRIC EMERGENCY: A STUDY OF PATTERNS OF SERVICE, 1966. $2.50 each; 5 or more copies $2.00 each.
☐ THE STAFF OF THE MENTAL HEALTH CENTER: A FIELD STUDY. Hardcover: $6.00 each; 4–9 copies $5.25; 10 or more copies $4.75 each.
☐ THE TREATMENT OF ALCOHOLISM. $3.00 each.
☐ TREATMENT OF DRUG ABUSE: A STUDY OF PROGRAMS AND PROBLEMS. $7.00 each.

(Bulk orders available from Publications Department, American Psychiatric Association, 1700 18th St., N.W., Washington, D.C. 20009. Discount for bulk orders.) The Joint Information Service is sponsored by the National Association for Mental Health and the American Psychiatric Association.

INDEX

In answer to many reader requests, here's the Annual Index to help you locate authors, titles, and topics, in 1974 issues. Page numbers are indicated by Arabic numerals, immediately following the season of issue.

TITLES AND SUBJECTS

A

AGING
Successful Aging, Summer 6
The Night of Ageism, Summer 13
Mental Health and Aging, Summer 21
An American Dilemma, Summer 26
The Real World, Summer 29
The Challenging of Aging, Summer 34
Administration for the Elderly, Summer 39

ALCOHOLISM
Turning a Problem Inside Out, Spring 25
One Vicious Circle, Spring 28

C

COMMUNITY MENTAL HEALTH
Model of a Program, Spring 36

CORRECTIONS
Controversy, Fall 8

COUNSELING
How to Handle Hotline Calls, Fall 10

D

DEPRESSION
"Buzz" Aldrin: I've Been There, Winter 4

E

ESSAY
Images, Winter 15
Bent to a Single Cause, Spring 21
The Orchestra, Summer 24
Untitled, Fall 14

L

LAW
Legal Advice for Psychiatrists, Winter 24
Dialogue in Dallas, Spring 6
The Insanity Defense: An Uncertain Future, Fall 4

M

MENTAL HEALTH
The Meaning of Emotional Maturity, Winter 9
Tragedy Examined, Fall 23

MENTAL HOSPITALS
The State Hospital: What Is Its Future?, Spring 11

P

POSITION PAPERS
NAMH on Psychosurgery, Winter 22

PROGRAM PLANNING
Citizens Making a Difference, Fall 16
Mental Health and Population Control, Winter 12
Mental Health Dilemmas in the Age of an Ecological Crisis, Fall 18

PSYCHIATRY
A Clear and Present Danger, Spring 17

PSYCHOSURGERY
Underlying a Method, Winter 19

R

RESEARCH
Research Still Holds the Answer, Winter 6

AUTHORS

Allen, Richard C., *The Insanity Defense: An Uncertain Future*, Fall 4
Breggin, Phyllis, *Underlying a Method*, Winter 19
Brody, Eugene B., *Mental Health and Population Control*, Winter 12
Butler, Robert N., *Successful Aging*, Summer 6
Dawidoff, Donald J., *Legal Advice for Psychiatrists*, Winter 24
Fine, Eric W., *Turning a Problem Inside Out*, Spring, 25
Folsom, Geneva S., *The Real World*, Summer 29
Folsom, James C., *The Real World*, Summer 29
Freedman, James O., *Administration for the Elderly*, Summer 39
Freedman, Joel, *One Vicious Circle*, Spring 28
Hampton, Peter J., *Tragedy Examined*, Fall 23
Hirschowitz, Ralph G., *Pattern for Change*, Summer 32
Kety, Seymour, S., *Research Still Holds the Answer*, Fall 6
Khajavi, Farrokh, *Model of a Program*, Spring 36
King, Glen D., *How to Handle Hotline Calls*, Fall 10
Linden, Maurice E., *The Challenge of Aging*, Summer 34
Perry, Jr., Bill, *Images*, Winter 15; *Bent to a Single Cause*, Spring 21; *The Orchestra*, Summer 24; *Untitled*, Fall 14
Perry, P. Wingfield, *The Night of Ageism*, Summer 13
Savitz, Harry A., *Mental Health and Aging*, Summer 21
Schapire, Hans M., *The State Hospital: What Is Its Future?*, Spring 11
Scoles, Pascal, *Turning a Problem Inside Out*, Spring 25
Sharfstein, Steven S., *Model of a Program*, Spring 36
Silber, David E., *Controversy*, Fall 8
Smith, Bert Kruger, *An American Dilemma*, Summer 26
Smitson, Walter S., *The Meaning of Emotional Maturity*, Winter 9
Szasz, Thomas S., *A Clear and Present Danger*, Spring 17
Tuteur, Werner, *Dialogue in Dallas*, Spring 6
Whittaker, James K., *Mental Health Dilemmas in the Age of an Ecological Crisis*, Fall 18

THE NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.

Founded by Clifford W. Beers in 1909, the National Association for Mental Health is a voluntary, citizens' organization dedicated to the improvement and protection of the mental health of the American people through a program of research, prevention, treatment and rehabilitation for the mentally ill and emotionally disturbed, and the promotion of mental health.

3/9/75

"It was like a trip through a tunnel of darkness."

Mental illness . . . the most frightening time I have ever been through in my life. Yet, I had known then about the Mental Health Association, I wouldn't have been in that tunnel of darkness for very long.

That's why the Mental Health Association is so close to my heart, for I have seen what it does. I have spoken to volunteers who go anywhere to talk to people who are as sick as I was, to give them the comfort of a smile, a word of understanding, of love.

If you need help, or can help, call your local Mental Health Association — citizens who do so very much for those who need so much.

Percy Knauth
1975 National Mental Health Chairman

Join and Support Your Mental Health Association

Citizens Who Do Make a Difference

SLEEPING GIANT
AMERICA'S ELDERLY

WITH SPECIAL VIEWS BY
ROBERT BUTLER
JAMES AND GENEVA FOLSOM
JAMES FREEDMAN
MARGARET HICKEY
MAURICE LINDEN
BILL PERRY, JR.
P. WINGFIELD PERRY
HARRY SAVITZ
BERT KRUGER SMITH

SUMMER 1974

The disappointment of manhood
succeeds to the delusion of youth.
Let us hope that the heritage
of old age is not despair.

Benjamin Disraeli

CONTENTS

2 [illegible]
5 [illegible]
6 [illegible]
13 [illegible]
21 [illegible]
24 [illegible]
26 [illegible]
29 [illegible]
34 [illegible]
39 [illegible]
44 [illegible]

NOTES

NAMH voices opposition to unrestrained experimentation involving children, and also patients and prisoners in institutions. In a position statement on the subject, the Association's Board of Directors has called for safeguards at least as stringent as those provided in HEW regulations issued on May 30, 1974, and special provisions published in the Federal Register of Nov. 30, 1973. "Without adequate safeguards," the statement reads, such research "may be a threat to life as well as a violation of individual and human rights." Accordingly, NAMH has urged its divisions and chapters to monitor this type of research and experimentation within their jurisdictions for compliance.

Success in court action. An ordinance involving the rights of former mental patients to live in hotels and rooming houses in Long Beach, N.Y., was declared unconstitutional by the Eastern District Court of New York (Stoner v. Miller). Judge Walter Bruchhausen held that the ordinance could "frustrate the movement towards deinstitutionalization in the treatment of the mentally ill."

Good news for former mental patients seeking Federal employment! The Civil Service Commission has ruled that "Question 29" will no longer be included on the CSC job application (Form 171). This question was used to screen the applicant who may have had, among other things, a "nervous breakdown." The ruling means now that an individual's medical suitability will not be considered until such time as he or she becomes a serious candidate for a particular position. This determination will then be made at the local place of employment after medical review, not at CSC Headquarters in Washington. The Mental Health Association, in concert with a number of other organizations, had been working hard for this change over the past several years.

Discharged patients have a fairly good chance of being hired in Scioto County, Ohio, found psychologist Joseph M. Carver of the Portsmouth, Ohio, Receiving Hospital. When asked, "Would you hire someone recently discharged from a community mental health facility, assuming he's qualified," 70 percent of small employers said, "Yes." Among large employers surveyed, 91 percent said, "Yes."

Youngsters assume doctors' responsibilities in the miniature hospital developed by Betty Lovelace, pediatric recreation director of the Stanford University Medical Center. The purpose of the handcrafted replica, equipped to the minutest detail, is to help children cope with hospitalization. The concept is Swedish psychologist Erik Erikson's--if children can master an experience in miniature, they can transfer that sense of control to the normal environment.

"Journey" wins award at the Seventh Annual Atlanta International Film Festival. Reviewed with 2,000 entries from 32 nations, the latest NAMH production was described as a "superbly creative film." For more information, see p. 4.

Guidelines for aging drivers are being studied by the American Medical Association as an outgrowth of its recent National Conference on the Aging Driver, in Washington, D.C. "Much of our elderly population is socially isolated in areas where services needed for daily living are not readily available without private transportation," said Dr. George G. Reader of Cornell University in keynoting the conference. Included among conference proposals were retraining courses to help older drivers overcome age-related driving handicaps. States were also asked to consider limited and restrained licenses that would still permit the older driver to get around his neighborhood.

> Enjoy your job and live longer, advise Duke University researchers who recently conducted a longitudinal study of the aging. Results of the survey using elderly subjects indicated that those who eventually lived the longest were the very ones who took pleasure in their jobs. A similar Duke project produced the same conclusion, but backwards. Focusing on working subjects, the study shows that cardiovascular disorders are significantly higher among those reporting marked job dissatisfaction.

Nursing homes scored by psychologist. Calling them "one of the worst institutions devised by man," University of Chicago professor Robert L. Kahn offered some alternatives to the homes. Among them is a program by the city's Council of Jewish Elderly, where people live in their own homes with housekeepers to help them if necessary. Supplemented by a minimum of outside services, this and other programs are based on the premise--"if people know help is nearby, they will call on it only when needed." Kahn and Steven H. Zarit discuss nursing homes and these alternatives in the recently released book, EVALUATION OF BEHAVIORAL PROGRAMS IN COMMUNITY, RESIDENTIAL AND SCHOOL SETTINGS.

> Elderly people living alone receive free daily telephone calls--courtesy of Northern Virginia Mental Health Association volunteers. This service also includes providing transportation for the elderly, inviting them into homes and taking them out for meals.

Psychiatrists have oversold the public on their accomplishments. That's the feeling of Harvard psychiatry professor Dr. Leon Eisenberg. Although psychiatrists point to the fact that more patients are being discharged from mental hospitals, they fail--claims Eisenberg--to report that 30 to 50 percent of schizophrenic patients will be readmitted within 1 year and 60 to 70 percent within 5 years.

> Social workers to benefit from insurance industry "first." The Union Labor Life Insurance Company now recognizes social workers as independent practitioners eligible to receive payment or reimbursement for administering professional health-related services. In the past, restrictions have required medical referral and supervision before reimbursement could be made.

MOVING? PLEASE NOTIFY US 4 WEEKS IN ADVANCE

Attach mailing label here, fill in new address below and send to: MH SUBSCRIPTION OFFICE, 49 Sheridan Ave., Albany, N.Y. 12210.

Name_____

New Address _____

City _____ State_____ Zip _____

TO WRITE ABOUT YOUR SUBSCRIPTION: Change of address, billing adjustment, complaint, renewal—address: MH SUBSCRIPTION OFFICE, 49 Sheridan Ave., Albany, N.Y. 12210. (Attach present address label in space provided. If you are receiving duplicate copies, please attach both labels.) This will help us identify you quickly and accurately.

TO ORDER A NEW SUBSCRIPTION: Check box ☐ and use form above. Mail to MH SUBSCRIPTION OFFICE at the address given. Or for faster service and attention, you can simply call (518) 436-9686. Subscription rate: U.S., 1 year $10.00; in Canada, $10.25; other countries, $10.50.

TO WRITE ABOUT EDITORIAL CONTENTS: Address: MH, 1800 N. Kent St., Arlington, Va. 22209.

COMMENTARY

Margaret Hickey

This issue of MH brings together both policy and program answers to the dilemma that faces people of all ages to some degree. Will age bring maturity and capacity to meet life's demands or will the future be filled with dependency and deterioration of both physical and mental abilities?

P. Wingfield Perry, in a provocative and timely article, examines *ageism*—that most pervasive form of discrimination—and what can be done to combat it. And in Dr. Maurice Linden's *The Challenge of Aging*, we are reminded that older people still have the capacity for growing *up* and not down. Certainly this corresponds to insights I've drawn from study, research, and over 40 years of varied and changing involvement.

Such a positive approach to the problems of the aging, however, is beset with old myths and stereotypes surrounding the needs of the elderly and, above all, their ability to help themselves and contribute actively to society. Only by exploding the myths and coming to grips with the realities of our society, can we arrive at Dr. Robert Butler's idea for the successful living of the added years that medical and psychological advances have given us.

To equate chronological age with biological and physical age is one of the most destructive attitudes in our culture, and it undermines the capacity of the elderly to maintain their independent status. All too often, we forget that they have the right to use their talents and should not be forced to bury them. Such age discrimination remains one of the most blatant and unchecked forms of bias.

Mentally frail, elderly people and those requiring hospital and residential care are a minority within the aging population and because they are a minority, the meeting of their needs is crucial and must be done by concerned and caring citizens—both professional and volunteer. The social health of all citizens is dependent upon meeting this responsibility. As yet, too few local communities have discovered the importance of providing community-based alternatives to long-term care of a new and innovative character. A few of these are centers for the aging, home health aides and homemakers, meals on wheels, and out-reach volunteers for those unable to communicate their distress.

While the limitation of resources must be recognized, a more equitable and just allocation is a major priority for widening the scope and availability of services to the elderly. The importance of planning for comprehensive health services, plus knowledge and experience obtained at the local level and backed up by research cannot be overemphasized. As these timely articles indicate, there is also a new emphasis on the contribution of community work as part of mental health planning and the participation in community development activities as a means of helping the elderly solve their own problems.

Most important of all, these authors are warning us that the elderly are not objects of treatment, of welfare, or even of compassion, but people with the capacity to be active agents on their own behalf, even though they suffer from handicaps or impairments. They are not merely passive consumers; they have a real role to play whenever possible.

Emerging needs, of course, must always be considered within the context of continued economic and social change. Bert Kruger Smith's *An American Dilemma* introduces the *person in the middle*. Often, parents with children in the expensive and lengthening years of educational dependency, discover their own aging parents to be equally dependent upon them. As a result, the three generations find themselves in need of counseling and community resources to share the burden of anxiety confronting them. Community mental health centers offer excellent points for this referral.

Enlightened social policies for our larger population—now growing older—is clearly one of the great public issues of our times, and every private citizen has a public duty to share in their creation.

Margaret Hickey is Public Affairs Editor of Ladies' Home Journal. *She is also a member of the NAMH Board of Directors and chairwoman of the Association's 1974 Annual Meeting Planning Committee.*

SUCCESSFUL AGING

By Robert N. Butler, M.D.

One of James Thurber's fables tells of a man who reported to his wife that he saw a unicorn in his garden. Thinking her husband had lost his mind, she surreptitiously called the police and a psychiatrist. However, it was a setup, and they took her away instead. The husband tricked the police and the psychiatrist into thinking his wife had made it all up. The American humorist always offered morals at the conclusion of his fables, and in this case, it was: *Don't count your boobies before they are hatched.* Those who think of older people as boobies, crones, witches, old biddies, old fogies, as out-to-pasture, boring, garrulous, pains-in-the-neck, as unproductive, worthless people, have another think coming. They had better not count their boobies before they are hatched. Great numbers of old people need not be and are not in institutions and, given a fighting chance in a society that has devalued them, can maintain a viable place in society. Indeed, at any one moment of time, 95 percent of the persons over 65 live in the community. In our social policies and in our therapeutic programs we need, of course, to have in mind a basic standard of health and not have our thinking dominated by stereotypes of frailty, psychopathology, senility, confusion, decline, and institutionalization. However, there is, of course, no point to developing illusions concerning healthy, successful old age. Like all periods, it has its difficulties. There are problems to be dealt with. There are needs to be fulfilled. But old age can be an emotionally healthy and satisfying time of life, with a minimum of physical and mental impairments. Many older people have adapted well to their old age with a minimum of stress and a high level of morale.

continued

Dr. Butler is Research Psychiatrist and Gerontologist for the Washington School of Psychiatry, where he serves on the faculty. For a review of his definitive work, Aging and Mental Health: Positive Psychosocial Approaches, *see p. 47.*

Study of *normal* development has seldom gone beyond early adult years, and the greatest emphasis has been on childhood. There have been relatively few centers for the study of adult human development. These centers have studied small population samples, usually of white, affluent middle-class people, composed about equally of men and women. This work at the University of Chicago, Duke University, the University of California and, for a brief period, at the National Institute of Mental Health has helped provide us with some understanding of successful mental health in aging.

In our culture few people think of old age as a time of potential health and growth. This is partly realistic, considering the lot of so many older people who have been cast aside, become lonely, bitter, poor, and emotionally or physically ill. American society has not been generous or supportive of the *unproductive*—in this case, old people who have reached what is arbitrarily defined as the retirement period. But in a larger sense, the negative view of old age is a problem of Western civilization.

The Western concept of the life cycle is decidedly different from that of the Orient, since it derives from an opposite view about what *self* means and what life is all about. Oriental philosophy places the individual self, his life span, and his death *within* the process of human experience. Life and death are familiar and equally acceptable parts of what self means. In the West, on the other hand, death is considered outside of the self. To be a self or person one must be alive, in control, and aware of what is happening.

The greater and more self-centered or narcissistic Western emphasis on individuality and control makes death an outrage—a tremendous affront to man rather than the logical and necessary process of old life making way for new. The opposite cultural views of East and West evolve to support two very different ways of life, each with its own merits. But the Western predilection for *progress*, conquest over nature, and personal self-realization has produced difficult problems for the elderly and for those preparing for old age.

This is particularly so when the national spirit of a nation and of an historical period have emphasized and expanded the notion of measuring human worth in terms of individual productivity and power. Thus, old people are led to see themselves as *failing with age*—a phrase that refers as much to self-worth as it does to physical strength.

In our culture few people think of old age as a time of potential health and growth.

Religion has been the traditional solace by promising another world wherein the self again springs to life, never to be further threatened by loss of its own integrity. Even though Western man's consummate dream of immortality is fulfilled by it, the integration of the aging experience to his life process still remains incomplete. Increasing secularization produces a frightening void that frequently is met by avoiding and denying the thought of one's own decline and death, and by forming self-protective prejudices against old people.

In some respects, we have come now to deal somewhat more openly with death itself. But aging—that long prelude to death—has become a kind of obscenity, something to avoid.

Medicine and the behavioral sciences have mirrored social attitudes by presenting old age as a grim litany of physical and emotional ills. Decline of the individual has been the key concept; neglect, a major treatment technique. Until about 1960 most of the medical psychological, psychiatric, and social work literature on the aging was based on experience with the sick and the institutionalized, even though only 5 percent of the elderly were confined to institutions.*

The few research studies that have concentrated on the healthy aged give indication of positive tential. But the general, almost phobic, dislike of aging remains the norm, with healthy old people being ignored and the chronically ill receiving half-hearted custodial care. Only those elderly who happen to have exotic or *interesting* diseases or emotional problems, or substantial financial resources ordinarily receive the research and treatment attention of the medical and psychotherapeutic professions

Health care is approaching a $100 billion-a-year business—second only to the food industry. However, the health care industry does not reflect the various human ills in due proportion. Although chronic disease accounts for two-thirds of our nation's health costs, certainly two-thirds of our medical school curriculum, medical manpower, intellectual emphasis, research, health delivery system are not devoted to this important group of diseases. With the advent of a national health insurance plan and the struggle that is now beginning to ensue in Congress and in the Administration with respect to the character of that insurance plan, it has to be recog-

* This 5 percent is a most significant minority, of course, with major needs. And, ultimately, some 20 percent of older people require institutional care, at least under the current health care system that does not provide comprehensive home care.

nized that none of the plans under consideration face realistically the facts of life, disease, and aging.

What is healthy old age? To begin with, one must remember that science and medicine have historically been more concerned with treating what goes wrong than with clarifying the complex interwoven elements necessary to produce and support health. Typical of this is the treatment of coronary attacks after the fact rather than prescribing a preventive program involving diet, exercise, protection from stress, and the absence of smoking. Most of the elderly's major diseases could be cited as examples of this same phenomenon. The tedious and less dramatic process of prevention requires an understanding of what supports or what interferes with healthy development throughout the course of life. We spend only 4 cents of every health dollar on prevention.

In 1946 the World Health Organization defined health as *a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.* This definition represents, of course, an ideal with many possible interpretations. But the three components of health—physical, emotional and social—compose the framework in which one can begin to analyze what is going well in addition to what is going wrong. The attempt must be made to locate those conditions that enable humans to thrive and not merely survive.

We cannot look at health simply as statistical or typical. If that were the case, dental caries, which affects about 90 percent of the population, might be considered healthy. Moreover, health cannot be looked at simply as a state. It is a *process* of continuing change and growth. What may be apparent health at one moment in time may already contain the beginnings of illness to develop fully in still another moment.

Old age is a period where there is unique developmental work to be accomplished. Childhood might be broadly defined as a period of gathering and enlarging strength and experience; whereas, the major developmental task in old age is to clarify, deepen, and find use for what one has already obtained in a lifetime of learning and adapting. The elderly must teach themselves to conserve their strength and resources where this is necessary, and to adjust in the best sense to those changes and losses that occur as part of the aging experience.

The ability of the elderly person to do this is contingent upon his physical health, personality, earlier life experiences, and the societal supports (adequate finances, shelter, medical care, social roles, recreation) he receives. It is imperative that old people continue to develop and change in a flexible manner if health is to be promoted and maintained. Failure to adapt at any age, under any circumstances, can result in a physical or emotional illness. Optimum growth and adaptation may occur all along the course of life, when the individual's strengths and potentials are recognized, reinforced, and encouraged by the environment in which he lives.

The major developmental task in old age is to clarify, deepen and find use for what one has already obtained in a lifetime.

To develop, then, a clear depiction of what old age can be like, we must contrast the mythological with a realistic appraisal of old age. Let me present a sketch that I first gave in 1959 to a group of nursing home owners in Maryland. This is the stereotype of old age, and it hasn't changed much in the last 15 years.

An older person thinks and moves slowly. He does not think as he used to, nor as creatively. He is bound to himself and to his past and can no longer change or grow. He can neither learn well nor swiftly, and even if he could, he would not wish to. Tied to his personal traditions and growing conservatism, he dislikes innovations and is not disposed to new ideas. Not only can he not move forward, he often moves backwards. He enters a second childhood, caught often in increasing egocentricity and demanding more from his environment than he is willing to give to it. Sometimes he becomes more like himself, a caricature of a lifelong personality. He becomes irritable and cantankerous, yet shallow and enfeebled. He lives in his past. He is behind the times. He is aimless and wandering of mind, reminiscing and garrulous. Indeed, he is a study in decline. He is the picture of mental and physical failure. He has lost and cannot replace friends, spouse, jobs, status, power, influence, income. He is often stricken by diseases which in turn restrict his movement, his enjoyment of food, the pleasures of well being. His sexual interest and activity decline. His body shrinks; so, too, does the flow of blood to his brain. His mind does not utilize oxygen and sugar at the same rate as formerly. Feeble, uninteresting, he awaits his death, a burden to society, to his family, and to himself.

There are certain major associated myths. There is *the myth of aging itself*—the idea of chronological aging, measuring one's age by the number of years one has lived. It is clear that there are great differences in the rates of physiological, chronological, psychological, and social aging from person to

continued

person and also within each individual.

Then there is *the myth of unproductivity*. But in the absence of diseases and social adversities, old people tend to remain productive and actively involved in life. There are dazzling examples like the 82-year-old Arturo Rubenstein working his hectic concert schedule; or of the 72-year-old Benjamin Dugger discovering the antibiotic aureomycin. Numbers of people become unusually creative for the first time in old age, when exceptional and inborn talents may be discovered and expressed. In fact, many old people continue to contribute usefully to their families and community in a variety of ways, including active employment.

Third, there is *the myth of disengagement* that older people prefer to be disengaged from life, to withdraw into themselves, choosing to live alone or perhaps only with their own peers. Ironically, a few gerontologists hold these views. One study, *Growing Old, the Process of Disengagement*, presented a theory that mutual separation between the aged person and society is a natural part of the aging experience. There is no evidence to support this as a generalization. Disengagement is only one of the many patterns of reaction to old age.

Fourth is *the myth of inflexibility*. The ability to change and adapt has little to do with one's age and more to do with one's lifelong character. But even this statement has to be qualified. One is not necessarily destined to one's character in earlier life. The endurance, strength, and stability in character structure are remarkable and protective, but most, if not all, people change and remain open to change throughout the course of life right up to its termination unless, of course, they are affected by major, massive destruction of brain tissue, illiteracy, or poverty.

Fifth is *the myth of senility*—the notion that old people are or inevitably become senile, showing forgetfulness, confusional episodes, and reduced attention. This is widely accepted. Senility, in fact, is a layman's term—unfortunately used by doctors to categorize the behavior of the old. Some of what is called senile is the result of brain damage. But anxiety and depression are also frequently lumped in the same category of senility, even though they are treatable and reversible. Old people, like the young, experience a full range of emotions, including anxiety, grief, depression and paranoid states. It is all too easy to blame age and brain damage when accounting for the mental problems and emotional concerns of later life.

Senility is a layman's term unfortunately used by doctors to categorize the behavior of the old.

Drug tranquilization—much overused in the United States—is another frequently misdiagnosed, but potentially reversible, cause of so-called senility. Malnutrition and unrecognized physical illnesses such as congestive heart failure and pneumonia may produce *senile behavior* by reducing the supply of blood, oxygen, and food to the brain. Alcoholism, often associated with bereavement, is another cause. Late-life alcoholism is a serious and common problem.

Now, of course, irreversible brain damage is no myth, and cerebral arteriosclerosis or hardening of the arteries of the brain and so-called senile brain disease marked by the mysterious dissolution of brain cells are major and serious conditions that do impair human development in old age.

Sixth is *the myth of serenity*. In contrast to the previous myths that view the elderly in a negative light, this myth portrays old age as a kind of adult fairyland. Old age is presented as a time of relative peace and serenity, when people can relax and enjoy the fruits of their labors after the storms of life are over. Visions of carefree, cooky-baking grandmothers and rocking-chair grandfathers are cherished by younger generations.

However, older persons experience more stresses than any other age group, and these stresses are often devastating. Depression, anxiety, psychosomatic illnesses, paranoid states, garrulousness, and irritability are some of the internal reactions to them.

Depressive reactions are particularly widespread in late life. In fact, *25 percent of all suicides in the United States occur in people over 65*.

Another frequent companion of old age is grief, either for one's own losses or for the ultimate loss of oneself. Apathy and emptiness are common sequels to the initial shock and sadness that follow the loss of close friends and relatives. Physical disease and social isolation can follow bereavement.

Anxiety is another common feature. There is much to be anxious about, with poverty, loneliness and illness heading the list. Anxiety may manifest itself in many forms—rigid patterns of thinking and behavior, helplessness, manipulativeness, restlessness and suspiciousness, sometimes to the point of paranoid states.

The stereotyping and myths surrounding old age can partly be explained by lack of knowledge and by insufficient daily and/or professional contact with varieties of older people. But there is another powerful factor operating—a deep and profound prejudice against the eld-

erly, which is found to some degree in all of us.

In thinking about how to describe this, I coined the word *ageism* in 1968:

> *Ageism can be seen as a process of systematic stereotyping of and discrimination against people, because they are old—just as racism and sexism can accomplish this with skin color and gender. Old people are categorized as senile, rigid in thought and manner, old fashioned in morality and skills. Ageism allows the younger generations to see older people as different from themselves. Thus, they subtly cease to identify with their elders as human beings.**

Over the years I have tried to enumerate certain characteristics that help define tendencies to be observed in older people. They are not inevitable nor are they found to the same degree in each person who manifests them. They do show themselves regularly enough to be considered typical of people who have lived a long time and are viewing the world from the special vantage point of old age.

Old age is the only period of life with no future. Therefore a major task in late life is learning not to think in terms of the future. Children are extremely future-oriented and look forward to each birthday as a sign of growing up. The middle aged, as Schopenhauer said, begin to count the number of years they have left before death rather than the number of years since birth. In old age, one's time perspective is shortened even further as the end of life approaches. Some avoid confronting this fact by retreating to the past. Others deny their age and continue to be future-oriented. The latter are the people who fail to make wills, leave important relationships unresolved, put off enjoyments, and experience boredom.

A more satisfying resolution is found among those elderly who begin to emphasize the quality of the present, of the time remaining, rather than the quantity. When death becomes imminent, there tends to be a sense of immediacy, of the here and now, of living in the moment.

Only in old age can one experience a personal sense of the entire life cycle. This comes to its fullness with the awareness of death in the forefront. There is the unfolding process of change, the experiencing of a sense of time, the seasoning or sense of life experience with a broadening perspective and the accumulation of factual knowledge of what is to be expected at the different points of the life cycle.

Older people are learning to assert themselves for what they need thereby winning self respect.

Old age inaugurates the process of the *life review*, promoted by the realization of approaching dissolution and death. It is characterized by the progressive return to consciousness of past experience, in particular the resurgence of unresolved conflicts that can now be surveyed and integrated. The old are not only taking stock of themselves as they review their lives; they are trying to think and feel through what they will do with the time that is left and with whatever material and emotional legacies they may have to give to others.

They frequently experience grief. The death of others, often more than their own death, concerns them. Perplexed, frightened at being alone and increasingly depressed, they at times become wary or cautious to the point of suspicion about the motivations of others. If unresolved conflicts and fears are successfully reintegrated, they can give new significance and meaning to an individual's life, in preparing for death and mitigating fears.

What can we do to help move society to a more balanced view of older people, and how can we help older people to prevent problems in later life and to favor successful aging? How can we treat already troubled older people to help them successfully age? We cannot review all of the relevant factors, of course. They vary from preventive measures like a major attack on the known antecedents of arteriosclerosis that requires change in dietary habits and physical activity. We must certainly face the enormous problem of alcoholism in the United States. Many people with lifelong excessive alcoholic intake are now surviving into old age, and many older people are taking up alcohol following grief and loneliness.

There is the need for a major reformation of our culture's sensibility toward old people through use of the media, which can help transform our views of what older people are really like and how to help them enhance their sense of themselves. There is also the political approach. Older people are learning to assert themselves for what they need, thereby winning self respect.

There are two forms of psychotherapy that can be helpful to older people, from both the preventive and therapeutic perspectives. These two treatment forms I call *life review therapy* and *life cycle group therapy*.

Life review therapy includes the

continued

* Butler, R.N. "Ageism: Another Form of Bigotry." *The Gerontologist* 9:243-46, 1969.
Butler, R. N. and Lewis, Myrna I. *Aging and Mental Health*. St. Louis, Missouri: The C. V. Mosby Company, 1973.

taking of an extensive autobiography from the older person and from other family members. Such memoirs can also be preserved by means of tape recordings, of value to children in the family. In instances of persons of note, memoirs have considerable historical importance and should be placed in archives for many reasons, including furthering our understanding of creativity and improving the image of our elders. The use of the family album, the scrapbook and other memorabilia, searching out of geneologies and pilgrimages back to places of emotional import evoke crucial memories, responses and understanding in patients.

The consequences of these steps include expiation of guilt, exorcism of problematic childhood identifications, resolution of intrapsychic conflicts, reconciliation of family relationships, transmission of knowledge and values to those who follow, and renewal of the ideals of citizenship

Such life review therapy can be conducted in a variety of settings from outpatient, individual psychotherapy to counseling in senior centers to skilled listening in nursing homes. Even non-professionals can function as therapists by becoming trained listeners as older persons recount their lives. Many older people can be helped to conduct their own life reviews. The process need not be expensive.

Reminiscence of the old has all too often been devalued—regarded as a symptom, usually of organic dysfunction and felt to bespeak aimless wandering of the mind or living in the past. We recognize, of course, the value of reminiscence as seen in the great memoirs composed in old age, which may give fascinating accounts of unusual and gifted people.

We see the role of the life review in film and fiction. Ingmar Bergman's beautiful 1957 motion picture, *Wild Strawberries*, shows an elderly physician whose dreams and visions concerned his past as he changed from remoteness and selfishness to closeness and love. Literature is replete with examples of the life review. Ernest Hemingway's *The Snows of Kilimanjaro*, Samuel Beckett's *Krapp's Last Tape*, Leo Tolstoy's *The Death of Ivan Ilych.*

Since 1970 Myrna I. Lewis, a social worker colleague of mine, and myself have conducted four age-integrated psychotherapy groups of about 8 to 10 members each with one contrasting middle-aged group. We have integrated persons ranging from age 15 to over age 80 in each of the four groups, based on the belief that age segregation as practiced in our society leaves very little opportunity for the rich exchange of feeling, experience, and support possible between the generations.

Physicians and psychotherapists should not assume that nothing can be done for older people.

The groups are oriented toward persons experiencing a crisis in their life ranging from near normal to pathological reactions to adolescence, education, marriage or single life, divorce, parenthood, work and retirement, widowhood, illness and impending death. Thus, such groups are concerned not only with intrinsic psychiatric disorders but with preventive and remedial treatment of people as they pass through the usual vicissitudes of the life cycle.

Criteria for membership include absence of active psychosis and presence of life crisis, acute, subacute or chronic. Of course, reaction to life crises follow traditional diagnostic categories, including depression, anxiety states, hypochondriasis, alcoholism, drug misuse. Our groups are balanced for age, sex, and personality dynamics. We meet once a week for one-half hour. Individual membership in a group averages about 2 years. New group members are asked to participate for a minimum of 3 months.

The life cycle crises approach to group therapy is neither strictly encounter nor strictly psychoanalytic. Rather, it can be equally concerned with the interaction among group members as determined by reality and the past histories and problems of each member. The goal is the amelioration of suffering, the overcoming of disability, and the opportunity for new experiences of intimacy and self fulfillment.

We believe that both forms of therapy can be very useful in the nursing home, mental hospital and other institutions. Age integration helps to recapitulate the family—something woefully missing for many older people. The garrulousness of older people reflects a social symptom and an intense desire in the face of death to deal with one's individual life.

These are but two examples of how we can approach the older patient in and out of institutions. Indeed, older persons' families—when they exist (and we must remember that one-fourth of older people have no family at all)—can themselves participate in therapeutic processes.

When older people look back on their lives, they regret more often what they did not do rather than what they have done. Medicine should regret its failures to act responsibly in the health care—including mental health care—of older people. Physicians and psychotherapists should not assume that nothing can be done for older people. Nor should the public. No one should count older people as boobies before they are hatched. ■

By P. Wingfield Perry

THE NIGHT OF AGEISM

Do not go gentle into that good night,
Old age should burn and rave at close of day;
Rage, rage against the dying of the light.
Dylan Thomas, *Collected Poems*
New Directions, 1957

Don't call me a retired person —a retired person is a loafer, a goof-off—a person with no options, forced to leave his job, no opportunity for others. . . ." "Don't call me a senior citizen—I'm simply an older person."

The first comment was made by an older man who had sold his business and moved into a retirement community; the second, by a well-to-do woman in her seventies, still working part-time by her own choice to keep busy at something worthwhile.

These two people, and millions of others like them, are, in their own quiet way, raging against the dying of the light—the night of ageism. Ageism—the prejudiced attitudes of our society that say that there is something wrong with being old. To most people, being old seems to mean sick, senile, foolish, useless. Examination of this mythology reveals some interesting facts.

- *All old people are sick.* While approximately 86 percent of the elderly have chronic health problems, 81 percent move about on their own and only 5 percent are institutionalized, according to Butler and Lewis, in *Aging and Mental Health —Positive Psychosocial Approaches*, Mosby, 1973. One can only guess how better health care over the lifetime might have altered these figures. Clearly, too, *chronic conditions* limiting activity are not the exclusive property of the elderly and should not necessarily imply that one cannot function independently at work and play.
- *Senility automatically accompanies aging.* According to the U.S. Senate report (RN92-433), *Special Committee on Aging, Mental Health Care and the Elderly, Shortcomings in Public Policy*, "What appears to be senility . . . may often be a temporary physical or emotional condition caused by problems which may intensify in the later years of life: malnutrition caused by poor eating habits or poverty; overuse of pain relieving or tranquilizing drugs, some forms of kidney trouble . . . traumatic events, adverse environment . . ." Obviously, these conditions are treatable, and so-called senility is not necessarily part of old age.
- *Their skills are useless and irrelevant in today's world.* Asked what he disliked most about old age, one man listed *lack of belonging and a sense of being worthwhile and a feeling of being put on the shelf.* Mandatory retirement laws reinforce these feelings. In fact, one mental health worker stated, "I think retirement has killed a lot of people." Actually, there is no reason an engineer or corporate executive, for example, cannot continue to make a valuable contribution, but our society does not value experience as much as youth.
- *Old people are too set in their ways and don't like change.* An older woman answered this saying, "Age has nothing to do with your reactions—I'm a little slower to make judgments, but the qualities in people I like are still the same." She explained that young adults are *more prejudiced and rigid in their attitudes than children—who don't care how old you are*—and *teenagers are wonderful—much more broadminded than their parents.*
- *Sex is not for old people.* Our culture abounds with jokes about dirty old men or depraved older women who marry young men (who can be interested in only money or mothering, since older women are sexually undesirable). (Children oppose the remarriage of their parents, cannot visualize them in a satisfying sexual experience (without laughter or disgust). Actually, a satisfying sex life in youth and middle years is likely to continue into old age, unless medical reasons prevent it (unusual), just as problem attitudes about sex will continue into old age. Many old people accept the myth of diminishing interest and capacity for sex, and tend to feel guilty about their desires. Institutions deny these needs, making little or no provision for privacy and discouraging relationships between male and female residents. Since women live longer than men, they are likely to spend their later years frustrated and feeling guilty about their frustration.

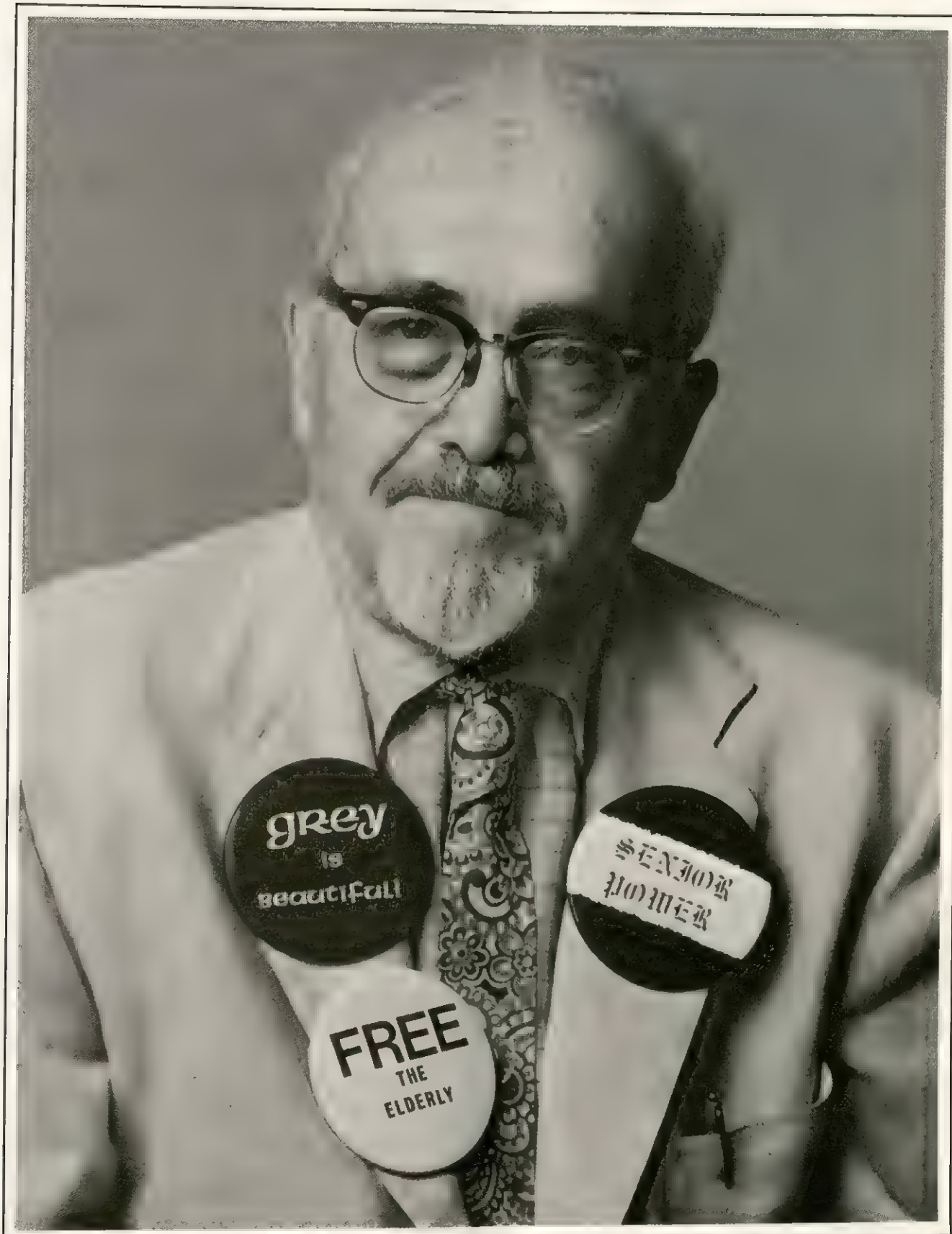
Ageism, like racism, manifests itself in every area of care for older citizens. For example, the Special Committee on Aging, U.S. Senate, reported in 1971 that, although one-fourth of all annual public hospital admissions are of 65 and over, only 3 percent of the budget of the National Institute of Mental Health (NIMH) was devoted to mental problems of the aged.

Authorities frequently list income, housing, and health as the three main problems of the elderly.

According to the latest government figures, 23 percent of the

Ms. Perry is a housewife and free-lance writer residing in Rockville, Md.

continued


grey
is
beautiful
FREE
THE
ELDERLY
SENIOR
POWER

Most authorities agree that underutilization of facilities can and should be overcome by taking care of the elderly where they are

elderly population is poor; 19 percent lived in substandard housing in 1960; and 87 percent have one or more chronic health conditions, with approximately 3 million having moderate to severe mental impairment.

What does this add up to for the elderly? Isolation—which then creates further problems such as poor nutrition, inadequate health care, confusion, depression. These, in turn, lead to further isolation, and we have a vicious circle.

Why does this situation continue to exist? Professor Brin Hawkins of Howard University in Washington, D.C., states, "We fear death and growing old and find reasons not to be around them." Mrs. Martha Jachowski, Montgomery County, Md., Mental Health Association, agrees, saying that "we are all frightened by geriatrics. . . ." She adds that a much greater effort should be made to prepare people for aging and retirement. Another older woman said, "We should start preparing at age 15—youth is not going to last forever."

This denial of the aging process and lack of preparation for it shows up in many places. For example, most medical schools do not train their students adequately in the problems of older patients. Doctors tend to avoid these cases when possible. Students, in general, are not encouraged enough to enter fields relating to the elderly. Most people get into it by accident, then become committed because of the great need and satisfaction in the work.

Godfrey Beckett, National Caucus on Black Aged, Inc., described how he became interested in the field. Some years ago, as a neighborhood worker for a community church, he was attempting to set up a *Meals on Wheels* program for the elderly. The resistant city official responded, "Let the old folks eat cat food; I understand it's very nourishing and good." Mr. Beckett's commitment was set.

Existing facilities, such as community mental health centers, are under-utilized by the elderly, according to Dr. Robert Butler, for a variety of reasons. He cites *lack of interest and therapeutic pessimism of both the "gatekeepers" and referral sources* (general practitioners and clergymen) *and mental health personnel.* "This," he says, "stems from inadequate education and experience on the part of the workers." Other reasons include lack of transportation and lack of awareness of the availability of help.

Most authorities agree that underutilization of facilities can and should be overcome by taking the care to the elderly *where they* [illegible] Programs such as Meals on Wheels, mobile health care units, home care visits, and day care centers are considered a vital part of mental health care for the elderly. All too often, old people are trapped by illness, lack of transportation, physical limitations and lack of knowledge of where to go, so they cannot seek help in the early stages of need. They become depressed (one of the most common conditions of the elderly), fail to eat, and may become confused. When they finally reach treatment, they may be diagnosed as senile or chronic brain syndrome, instead of undernourished, for example.

People growing old or already older mention such things as *fear of being a burden to my children,* loneliness, and loss of health as their great fears. One lady said that "making allowances for you is very annoying—deferring to your age, especially when you don't feel old." All these imply a strong desire for independence and dignity—things which ageism makes difficult to achieve.

Diminishing income due to inflation is another serious problem described eloquently in *The Washington Post* (April 27, 1974). "You simply can't imagine the feeling of helplessness that comes over you from time to time now, about what you'd do if the furnace conks out

or the plumbing goes. There's no reserve money for a replacement or repairs," a retiree told the *Post* reporter. Other, more horrible, stories —such as the elderly New York couple freezing to death after their heat was turned off—come to mind, illustrating the profound effect inflation has for those living on fixed incomes, i.e., social security.

Institutionalization of the elderly is another area of grave concern. Some people feel that state hospitals have been used to warehouse elderly people who should be in the community and could be, if there were any place for them. In response to this, screening projects have been set up in some locales to make sure that only those who really belong in institutions are placed there. Other authorities have expressed concern about keeping the elderly from entering hospitals and steering them to alternative services without adequately analyzing their merits and effect on the elderly involved.

These are some of the problems affecting the elderly in general. But, is there any aggravation of these problems as a result of being black or a member of another minority group? *Well, they die earlier, so the problem in later years becomes moot* was one response to that question. Another response was that *they take care of their own.*

Actually, while the general life expectancy of black men is 8 years lower than white men, their life expectancy, if they reach the age of 69, exceeds that of white men, according to Jacquelyne J. Jackson, in the December, 1972, issue of *Proceedings of Black Aged in the Future.* According to the 1970 U.S. Census, aged blacks constituted approximately 7 percent of the total black population. Forty percent were between 65 and 69; 16 percent were between 75 and 79; 9 percent were between 80 and 84; approximately 8 percent were 85 or more.

As for black families *taking care of their own*, they probably don't do this any more or less than any other group. Most families, white or black, attempt to care for their elderly members as long as possible and do not *dump* them in institutions, contrary to popular opinion.

Here are some statistics published by the National Caucus on Black Aged, Inc., which compare blacks and whites as to the severity of their problems:

- Fifty percent of the black elderly are poor; 23 percent of the elderly whites are poor.
- Most elderly black men had incomes of less than $3,000 in 1969; whites, approximately $6,000.
- Forty-seven percent of elderly black women had under $1,000 in annual income in 1969.
- Median incomes for husband and wife elderly blacks was $3,222 in 1969; $4,884 for whites.
- With a black woman as the head of the family, the median income was $2,511; for whites, it was over twice that amount.
- Sixty-three percent of elderly blacks moving into public housing come from substandard housing.
- Fifty-four percent of elderly blacks report a limiting chronic condition; 45 percent of the elderly whites report a limiting chronic condition.
- Elderly blacks have 19 bed-disability days per person per year; whites have 12 days.
- Blacks appear to utilize medical services less; two-thirds are not benefitting from Medicare.
- For the age group 45-64, the mortality rate for blacks is approximately twice as great for black women and more than 10 percent greater for black men than for whites in a similar age group.

Professor Clavin Fields, Inst. of Gerontology, Federal City College, D.C., gave a good example of the

Some people feel that state hospitals have been used to warehouse elderly people who should be in the community and could be, if there were any place for them

continued

Clearly, then, minority groups do have problems that merit special attention

effect of racism, stating that "whites are complaining about the terrible conditions of nursing homes that blacks are still trying to get into."

Although blacks appear to have more serious health problems (based on bed-disability days), they benefit less from Medicare/Medicaid. The reasons for this can be attributed to several factors, such as the establishment's failure to communicate these rights to older blacks, its inability to afford premiums and deductibles.

Professor Hawkins explained that because of their lifetime deprivation and cultural diet, many blacks are more susceptible to the symptoms of senility. Older black women exhibit symptoms of aging much sooner because of the lack of hormone treatments during menopause. Illustrating the results of prejudice against black women, Professor Fields said, "Most doctors would prefer to treat a young white woman, a middle-aged white woman, and even an older white woman than an older black woman."

Mr. Beckett feels that the "black elderly are still being held captive of the racist system they helped to change for younger blacks." Elaborating, he cited the role of the elderly blacks in the civil rights movement of the Sixties. These people did not benefit materially from their successes, but their children did.

Professor Fields pointed out that, since blacks don't usually live to collect social security, they are, in effect, subsidizing elderly whites who live substantially longer. He endorses the proposition that until the minority average age becomes comparable to the general population, minority groups should be able to collect on social security 8 years earlier (based on the fact that blacks die 8 years earlier).

Many blacks, because of their historically low income in menial jobs, collect much less than whites and require old age assistance. Other minority groups have similar problems, including language barriers. Clearly, then, minority groups do have problems that merit special attention.

Ageism, prejudice, health, housing, income, transportation—what does all this mean in terms of mental health? It means isolation and depression—factors obviously conducive to mentally *ill* health. Groups ignored and denigrated by s[illegible] must inevitably suffer from neg[illegible] self concepts and resulting d[illegible] sion, among other things.

Some things are being done ever, and authorities feel ther[illegible] light at the end of the tunnel. M[illegible] programs tried have been suc[illegible] ful, such as housing for the eld[illegible] Senior AIDES, and groups of el[illegible] (RSVP) helping themselves [illegible] others to take care of a variet[illegible] needs.

More needs to be done, tho[illegible] We have approximately 20 mi[illegible] elderly now, and this numbe[illegible] expected to increase. Some spe[illegible] areas for improvement are:

- *Enforcement of existing l[illegible] against discrimination.* T[illegible] will help minority groups g[illegible] access to existing facilities
- *Legal aid.* According to th[illegible] National Caucus on Bl[illegible] Aged, Inc., approximately [illegible] percent of all households di[illegible] placed by public action a[illegible] headed by elderly people. They are often taken advantage of by sellers of hearing aids that won't help them, and may be generally less knowledgeable about consumer rights.
- *More money for research for such organizations as* NIMH *and institutions of higher education.* According to Professor Fields, "not enough is known, and not enough that is known is utilized." He further stated that "most research is done on the sick elderly and very little on the well."
- *A continued varied approach.* All authorities agree that the elderly is a heterogeneous

continued

group, and within this general group the Blacks, Spanish, Chinese, and others are also heterogeneous groups with many different needs.

- *More trained people and more support for institutions in this training.* Most professionals in the field are white, and minority groups feel that more of their own people need to be trained as well as better preparing whites to deal with cultural differences of minority groups.
- *Active participation of the elderly themselves in planning for themselves.* Organizations such as the National Council of Senior Citizens, Inc., American Association of Retired Persons, Gray Panthers and others are growing at a fantastic rate, indicating an increased awareness on the part of the elderly of their rights and needs.
- *Beautify old age.* We must *be prepared to accept the changing phases of life*, according to a 73-year-old woman, and *end the glorification of youth.* "If we change our attitudes about aging, it will make people feel better about being old," stated Professor Hawkins. It will also make people less fearful of becoming old themselves and more responsive to the needs of the elderly.
- *Community Involvement.* Mental health associations have a unique opportunity and responsibility to penetrate the circle of isolation around the aging by including them in program planning and development, just as they are beginning to do with blacks and other minorities. Aging community leaders should be invited to participate as board, committee, and general members at reduced rates. This should not be done with the attitude of *what do you people want.* That is no more likely to work with aging than it did with blacks. Rather, it should be done on the basis of *we, the mental health associations, want to serve the whole community and we need your expertise.* Needless to say, envelope stuffing requires no expertise.
- *Education.* Pamphlets [illegible] tures, films, and other m[illegible] relating to the aging [illegible] health could be develop[illegible] educate the community, [illegible] elementary school on up[illegible] preparation for old age a[illegible] existing problems.

We must re-evaluate our priorities and assign a fair share of our assets to the problems of aging

Professor Hawkins predicted [illegible] in the coming years old people [illegible] experience an identity develop[illegible] similar to that which the b[illegible] have experienced in recent y[illegible] The National Council of S[illegible] Citizens has already noticed an in[illegible] creasing awareness on the pa[illegible] senior citizens. Recently, it [illegible] lished in its newsletter a list [illegible] legislators and their records reg[illegible] ing the aging. The members [illegible] most responsive to the list, an[illegible] legislators (unless their records [illegible] good) were very apprehensive ab[illegible] it.

What we see now is an increa[illegible] awareness of a set of formulae for aging:

- ☐ Old + poor = double jeopardy;
- ☐ Old + poor + minority = triple jeopardy; and
- ☐ Old + poor + minority + female = quadruple jeopardy

We must re-evaluate our priorities and assign a fair share of our assets to the problems of aging, to balance the equations of growing old in America.

That sleeping giant, the elderly in America, is beginning to stir, and, as Nathan Sloat puts it: "If the public does not respond, they are going to *throw the rascals out.*" ■

MENTAL HEALTH AND AGING

By Harry A. Savitz, M.D.

It is the tragedy of man that he begins to look with disdain on old age as he himself gets along in years. Everyone wishes to live long, but no one wants to be old. Man laments the brevity of life but when he achieves longevity, he is not content with his hoary age.

The complaints, resentments and discontentments of the aged are many, but on analysis many are not so dark as they are painted—nor are they all to man's disadvantage. The most frequent and general lament is that of weakness. Gone is the vigor, freshness and enthusiasm of youth. To be sure, youth is a race and old age is a walk. As the years go on, time becomes shorter and the distances become longer; one's pace is slower, and this is nature's way of prolonging life. One can often cover greater distances at a slower pace, sometimes overreaching the runner. As the Russian proverb puts it—the slower your ride, the further your travel. Experience may have taught a great many shortcuts that will compensate for the lack of speed.

Another common complaint of the aged is the loss of memory. It is a well-known adage that old age is the mother of forgetfulness. This, too, can be considered an advantage in some respects, for man would find it hard to live on if all the unhappy and unfavorable experiences of the past were to be clearly preserved in his mind. Just as the patient who has recovered from a critical illness forgets the frightening details, so must old age bury its dead past and involve itself in the pleasures that added years can bring. To be practical, if there are important details and facts that one really wishes to retain, these can be recorded in a small notebook. This helps to impress the fact on one's mind.

Most of the special facilities connected with bodily organs, such as hearing, do lose their acuity in the advancing years. We frequently hear the aged complain that their hearing is not what it used to be—quite correct. However, this *hard of hearing* in many cases is partly due to *hard of listening*, because the elderly have a tendency to be extremely loquacious. They narrate endlessly about their youthful pursuits and accomplishments, but they are not so generous in listening to the chattering of others. I would suggest to the mature elderly person that he lend his ears to his neighbor's tales as his neighbor does to his.

Among the host of woes of the aged is the lament that as they get older, they are subject to numerous illnesses. Of even greater concern is the fact that they look upon *old age* itself as a disease. This is not so; no more than that infancy or adolescence in themselves are diseases. During the early years, the young are subject to a number of children's diseases before they build up the bodily defense of immunity.

The functioning of the human body is miraculous in itself—the physiological function of the little finger is more complicated than any elaborate machine. So it is only natural when something in this complicated structure goes wrong occasionally. And the longer we live, the greater the chances are for malfunction in one organ or another. It is for this reason that we have medicines and physicians to administer them. I would urge the elderly to discuss their ailments with their physicians in the consulting room, and not to bewail their problems to friends or neighbors.

We find that many aged persons grumble about minor discomforts which, when put in proper perspective, may be considered an advantage. First and foremost is the ever-present murmur of poor appetite, for which there is a demand for a variety of tonics. As a rule, the aged person eats more than he should (another preoccupation) and consumes more calories than his daily requirement. Little do the aged realize that the poor appetite is nature's safeguard for the preservation of health. In fact, what we now diagnose as an acute heart attack (myocardial infraction) was often called acute indigestion at the beginning of this century, because it frequently occurred after heavy meals that triggered the attack.

Another constant complaint of the aged person is the problem of too much leisure time, and the dissatisfactions arising from this seem to be his major preoccupation. If some of this leisure time was devoted to a productive hobby, a great many symptoms of illness would vanish. This is the period in life when one can and should develop new and absorbing hobbies or further develop past interests for which there was not sufficient time in the busier years. A psychological definition of interest is background and as knowledge of a subject increases, so does interest. This interest may be compared to the structure of an edifice—the higher it rises, the deeper must be the foundation.

To live is to act—to do something that absorbs your mind and makes good use of your time—makes for an exciting existence. To

continued

Dr. Savitz is Physician-in-Chief, Emeritus Hebrew Rehabilitation Center for the Aged, Boston, Mass.

ABSORBING INTERESTS PROVIDE HAPPINESS AND CONTENTMENT IN LATER YEARS

be idle is to live in a vacuum, and this is detrimental to good health. Someone has said that an idle man is like a dead person, except that he occupies more space. Work is a source of joy to the mind and therapy for the body. Men, as a rule, are unnerved and worried when they are faced with retirement—not so much from the prospective loss of their positions as at the prospect of nothing to occupy their time.

Just as one plans financially for retirement, it is equally important to develop a program that will provide for absorbing interests to fill leisure hours later on. This makes for purpose in life and provides the happiness and contentment that one derives from doing something well that he enjoys doing. There are many skills that can be learned or further developed in the later years. When the elderly person continues the pursuit of knowledge he is doubly rewarded: first, by new knowledge that enriches his life by its actual possession; and secondly, by the therapy of mental activity.

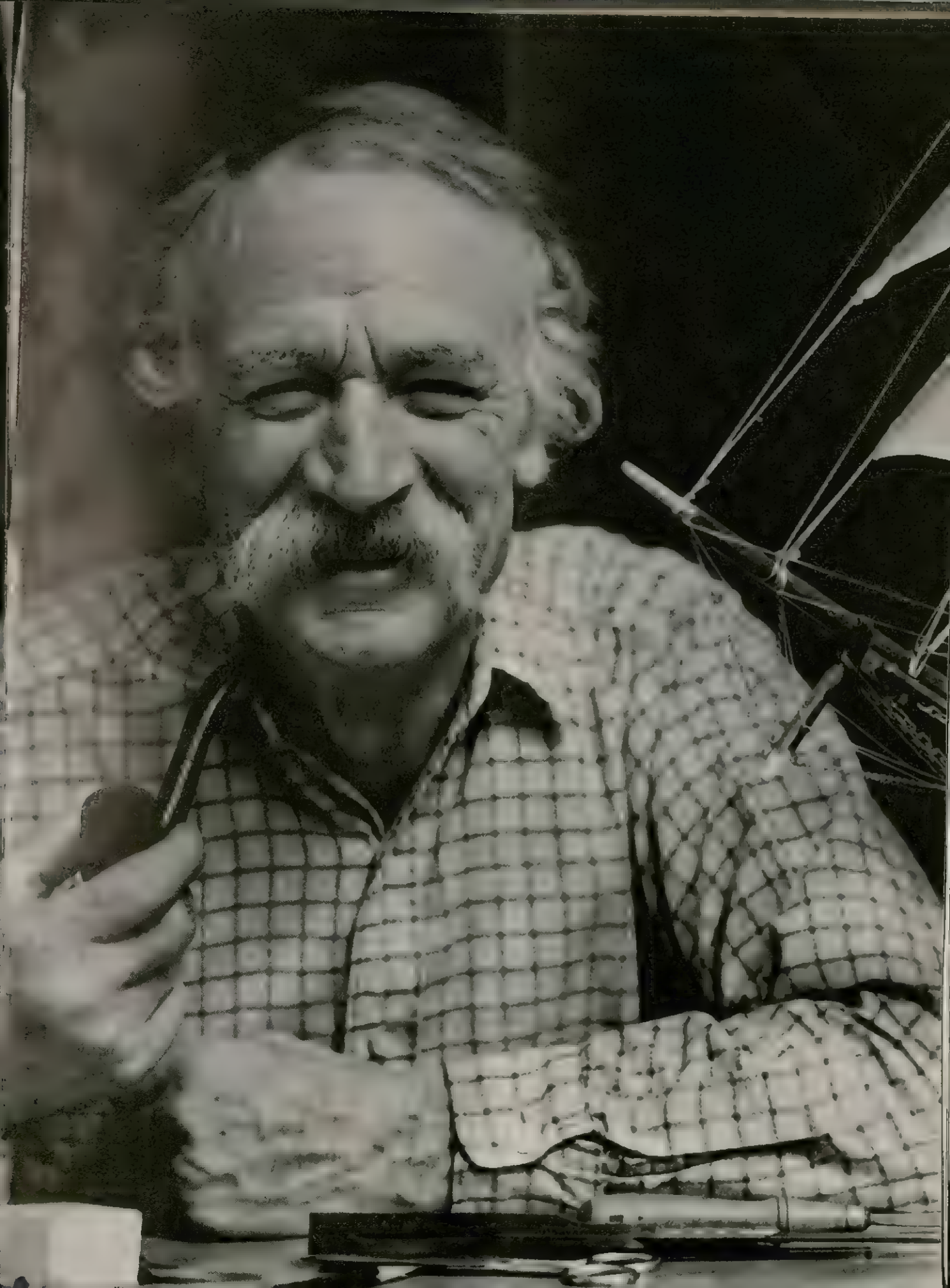
Most geriatricians find that the elderly patient often experiences loneliness. However, this feeling need not be a total disadvantage. In fact, it can at times provide an escape from tumult and allow for contemplation. Some of the most profound thoughts are developed when one is alone and undisturbed. Too much time alone sometimes brings on depression, but there are many remedies for this—among them, reading. Just as a daily walk helps to preserve the physical vigor of the body, a stroll through the garden of literature keeps the mind active and alert.

It is understandable that the older person experiences the loneliness and melancholy that comes when his friends pass on, one by one. This is truly a most distressing experience; but one must hold on to remaining friends and, at the same time, endeavor to enter into new relationships. Good friends increase your joys and share your sorrows. But, as is well known, one must give of himself to have a friend.

Another antidote against loneliness is to identify your individual life with that of the community in which you live, and do not stay apart from it. Take advantage of its facilities and programs and share in its weal and woe. The new associations made in these programs and causes bring stimulus to the mind, activity to the body, and relief from loneliness.

All in all, I would suggest that the elderly must realize that life is a continuous process of adaptations to its many stages. Each period in life has its advantages, its special joys, and its disadvantages and problems. As one lives on to a relatively long life, there are features that seem unpleasant—the lined face, the grey hair or lack of hair, and feet that are slow to run. Man must make a conscious effort to avoid boredom and the feeling of uselessness by utilizing his accumulated experience and wisdom.

As we grow more mature, we become more tolerant and perceive the latent qualities as well as the defects in people, and we do not expect perfection. Diamonds, even with slight imperfections, are still precious stones. In a sense, life at this period becomes more vivid and more of a challenge. ■



THE ORCHESTRA

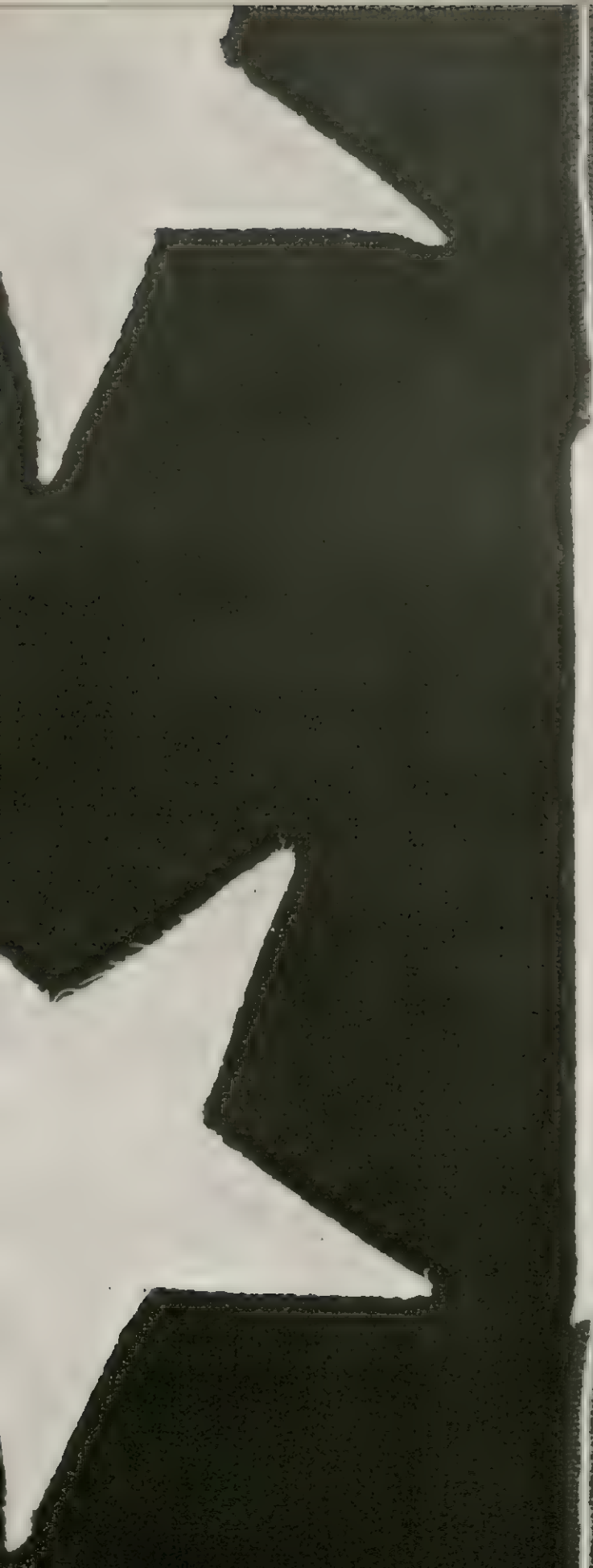
THE MUSIC CHANGES A LITTLE NOW. ALTERS ITS TEMPO, SOFTENS ITS SOUND, PLAYS TO THE PACE OF THE DANCERS. THE MUSIC, ITS BEAT STILL REGULAR, IS NOW MORE SYMPHONY THAN JAZZ, MORE CHAMBER THAN RAGTIME.

WITH LOVE, THE MUSICIANS MOVE THROUGH THE COMPLICATED SCORE, BLENDING THEIR INSTRUMENTS AND THEME INTO ONE. THEY URGE THEIR WORN TOOLS INTO EXTRACTING NUANCES FROM EVERY NOTE, WARMTH FROM EACH SHARP, PASSION FROM THE FLATS.

THE OLD CONDUCTOR UNDERSTANDS AS HE CALLS UPON EACH SECTION OF THE ORCHESTRA. HE SEIZES THE EMBERS AND TURNS THEM INTO BRIGHT FIRE, LIGHTING THE STAGE FOR ALL TO SEE. HE SEARCHES FOR THE BEST IN EACH PLAYER—NO MORE, NO LESS. INSTINCTIVELY HE KNOWS THAT EACH MUST CONTRIBUTE SO THAT ALL MAY ENJOY.

THE SOUND RISES NOW, PERFECTLY PACED. POINT, COUNTERPOINT, CRESCENDO, DIMINUENDO. IT IS THE SOUND OF AN OLD ORCHESTRA, WISE AND SURE, EXPERIENCED BEYOND ANY. PLAY ON, BEAUTIFUL ONES, PLAY ON! YOUR MUSIC IS THE SOUND OF LOVE.

BILL PERRY, JR.



An American Dilemma

Many books, articles, plays, and musical presentations have been composed about triangles. Generally, we think of a triangle as being a husband, wife and *other woman* phenomenon. But this one is different. It is composed of *you*, your almost grown child, and your parent or parents.

Such a situation is new to our times. Today, right now, about 4,000 Americans reached their 65th birthday; 3,000 died, leaving an extra 1,000 persons. Approximately one in 10 Americans is 65 or older. This number more than 20 million. By the year 2000 they will be closer to 30 million.

In the past 100 years our total population has grown to be five times as large as it was. Our middle-aged population is nine times as large, our older population 17 times greater.

People are living longer. The 1970 census showed that the age group of 75 and over grew faster than any other, meaning that many of us who are ourselves reaching retirement age and some long-promised leisure now find ourselves responsible for parents in their 80s and 90s.

In negative fashion, we witness the diminution of their energy and alertness. We grow impatient with waiting, walking slowly, repeating and repeating again.

Mrs. Smith is Executive Associate of the Hogg Foundation for Mental Health in Austin, Tex. She is also author of Aging in America, *a review of which appears on p. 44.*

☆ ☆ ☆ By Bert Kruger Smith

Why can't she remember that I was going to pick her up? we lament. Or *Why didn't he write down the message.* Sometimes, the elderly seem far too dependent, much too demanding. They talk independence, but they ask us for help at all our busiest moments. That's one picture of our old. Yet, there is another.

Even as they show their need for us, they often demonstrate courage in meeting pain with stoicism and loneliness with dignity. They bear the imprint of the past and, with their memories, help to tamp our roots into the loosened soil of the present. They give us history and example and a love that reaches across generations.

In addition to the parents who are living longer, we see young people staying dependent for increased periods of time. With the emphasis on higher education, they are financially dependent often well into their 20s or early 30s.

Again, negatively, we may see our young as nonconforming, rebellious, rejecting—particularly those who have chosen a life style contrary to our own. We wail *How could she do this to me?* or *Why can't he listen or mind as we used to do?* It's as if they were our very own possessions to continue in our mold for living. Sometimes today's youth seem far too unrealistic, much too independent. And even as they espouse independence, they call on us for financial help to get through school, to go to Europe, to buy a car. That's one picture of our young. But there is another.

If our older people are examples of history lived, our young are pictures of history to come—history which may be beyond our minds. The young—seen in a positive fashion—bring courage, strength, enthusiasm, and vision. They are the tomorrow to which our todays are aimed.

What does it mean, then, to be the person in the middle—planted firmly between the generations, balancing them both on the long poles of your life-shoulders, their dependence tied up in bags of needs at the end of the poles?

Do you long to set down your dual burdens and disappear to some quiet island of self? Does it seem unfair, untenable, and undesirable to have to march tiredly through the years maintaining their weight? And should you feel guilt for having those negative emotions?

Let us look at some of the means of weight-balancing. Physical therapists know that the means of carrying a load is more important than the weight of the item itself. Emotionally, the same is true. Good mental health lies in the ability to cope with problems, to balance troubles, to maintain mountain peak views while climbing the slope.

Carriers, no matter what their age, need to continue to reinvest in other people, else their loved ones, friends and family will be erased by ones and twos

continued

There needs to be a constant reaching out—upward and inward

from the blackboard of their lives. *Replacement therapy* might be the name given for this new commitment to others. If such therapy is practiced early and continually, the carrier will not himself grow old like some very old persons who have shrunk into a single room with their whole life bound by faded pictures on faded wallpaper and only one small window to let the day come in.

There needs to be a constant reaching out—upward and inward. The investment has to be in self-growth, in new *others*, in activities with meaning. Reaching out to others—strangers or persons who need friendship, concern, and the pleasure of conversation—is one of the best ways of putting aside personal feelings of hurt, dislike, resentment, and guilt. With a stranger, one starts clean—no buried angers, no unsettled fights, no ugly rivalries. Instead, there is the open and honest reaching of person to person in friendliness and warmth. This ability to share with a contemporary some of the fears and delights of a particular age is therapeutic.

What are some actions which you, the carrier, might take? First of all, you must see yourself—honestly, wholly, and without excuses. If the traits we have today —the interests, concerns, and activities—were enlarged and exaggerated, what kind of persons would we be? Compassionate? Intent? Loving? Or selfish, uninvolved, rejecting? *For we are what we were only more so and we are what we will be only less so.* Selfish tyrants do not generally turn into sweet old people. Possessive parents do not change into unselfish grandparents. Dependent persons do not become reliable because of added years.

Second, you need strength in order to carry both generations safely. But you should not feel guilty because of their weight, or because of fatigue or understandable impatience. Instead, you should find ways to set down your double load from time to time, to drink alone from life's waters, to sun in the rays of others.

Also, you should learn to find escape passages, to be able to shift the load to others at times. No generation has full call on any other. In the Viktor Frankl sense, we are charged with finding meaning, meaning for our own lives.

Third, you should find ways to make each generation learn to help the other—to reach out across the span of years. They should be encouraged to take responsibilities for themselves—to feel the needs of the carriers and respond to silent requests, to assuage guilt and understand fatigue. Conversely, you must remain whole, concerned and alert, even while carrying both the young and the old on your shoulders.

Each person, then, is responsible for his own life. It is that responsibility that sometimes seems like the burden—but a burden that can be lifted high off one's shoulders by understanding, self-awareness, and action on the part of all three generations. ■

By James C. Folsom, M.D., and Geneva S. Folsom, Ed.D.

THE REAL WORLD

If I don't know who I am, where I am, or what time of day or night it is, I am a non-person. If I am mentally and emotionally healthy, I have a great deal of insight into who I am. I know my own strengths, successes, values, satisfactory ways to problem-solve. I know where I have been and I have some directions in which I want to go. I accept different developmental stages and grow in new ways as I age. I solve conflicts as I mature so that I may solve new ones as they appear. I understand what effect I may be having on others, either individually or in a group. I understand ways in which I handle my own anxieties. I know my prejudices, my skills, and can accept my failures. In essence, I am a person. I am well oriented to time, place and person.

continued

Dr. James Folsom is Director of Rehabilitation Medicine Service, Veterans Administration, and Chairman, Psychiatric Services Section, American Hospital Association. He is also a member of the Menninger Foundation's Board of Trustees.

Dr. Geneva Folsom is Education Specialist for the Veterans Administration, and faculty consultant on aging, Catholic University. She is also a consultant in continuing education for the Ohio Department of Mental Health.

Most of us, even our oldest people, are well oriented. What happens to cause people to become disoriented? It can happen to anyone at any time. Yet if we are old, we are excused on the grounds of *senility*.

Confusion can result from drugs, particularly with older people whose tolerance level has decreased. It also may occur when we change environment, such as waking up in the middle of the night in a strange room while traveling. Other incidences include when we come out from under anesthetic after an operation. Or if we are traumatized, e.g., people have responded during an accident and later did not remember what they did. Even if we are anxiety ridden or have physical problems. It can also happen to a post-stroke victim and may be one evidence of brain-damage or the aftermath of a convulsion.

We do not need to wait for a definitive diagnosis of the reason or cause of the confusion. The confusion is important—not the diagnosis. The immediate need, when confronted with someone who seems confused, is to reorient them to time, place and person. If we do not help the confused person, we may well be adding to the confusion.

Confusion is often compounded unwittingly in a hospital setting. Most of us are anxiety ridden concerning hospitalization. If it's the result of an accident, we are even less prepared and less able to cope with the anxiety-producing situation.

Let's illustrate this with the case of the 82-year-old man who entered the emergency room of the small-town hospital, because he had failed to stop at a stop sign and was hit by a truck. By the time he had regained consciousness, he had been taken to the hospital, had a pin set in his hip, and been in a strange room for 2 hours. Four hours had elapsed since he had come to town to visit two of his sons.

When he comes out from under the anesthetics, no one bothers to tell him his name. The sons both say, "Hi, Dad!" and his wife calls him *Dear*. A nurse comes into the room, rolls him over, and gives him a sedative—without announcing who she is or calling him by name. No one tells him where he is.

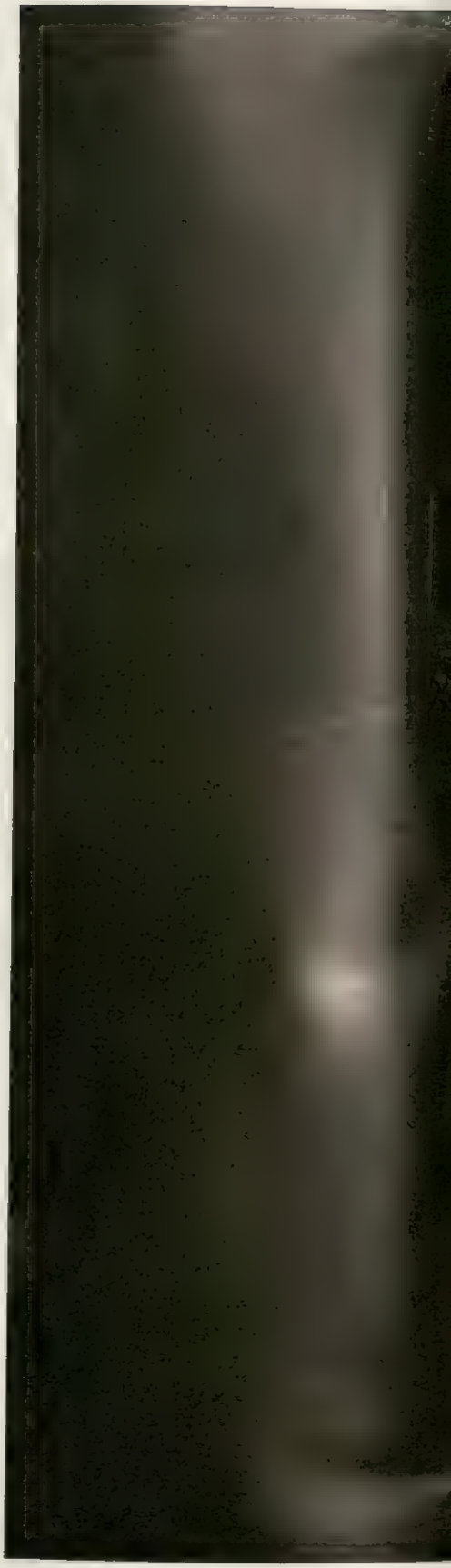
They just say, "You had a wreck and are in the hospital." So far, no one has given him any identity or real clues as to who he is, where he is, what time it is, or what day it is. There is no calendar on the wall, the curtains are drawn so he does not even know if it is day or night. He does recognize his sons, but he has seven and they all look somewhat alike. He has recently remarried after being married 55 years to his first wife. He calls this one by his first wife's name. Instead of correcting him, his second wife says, "Now, Dear."

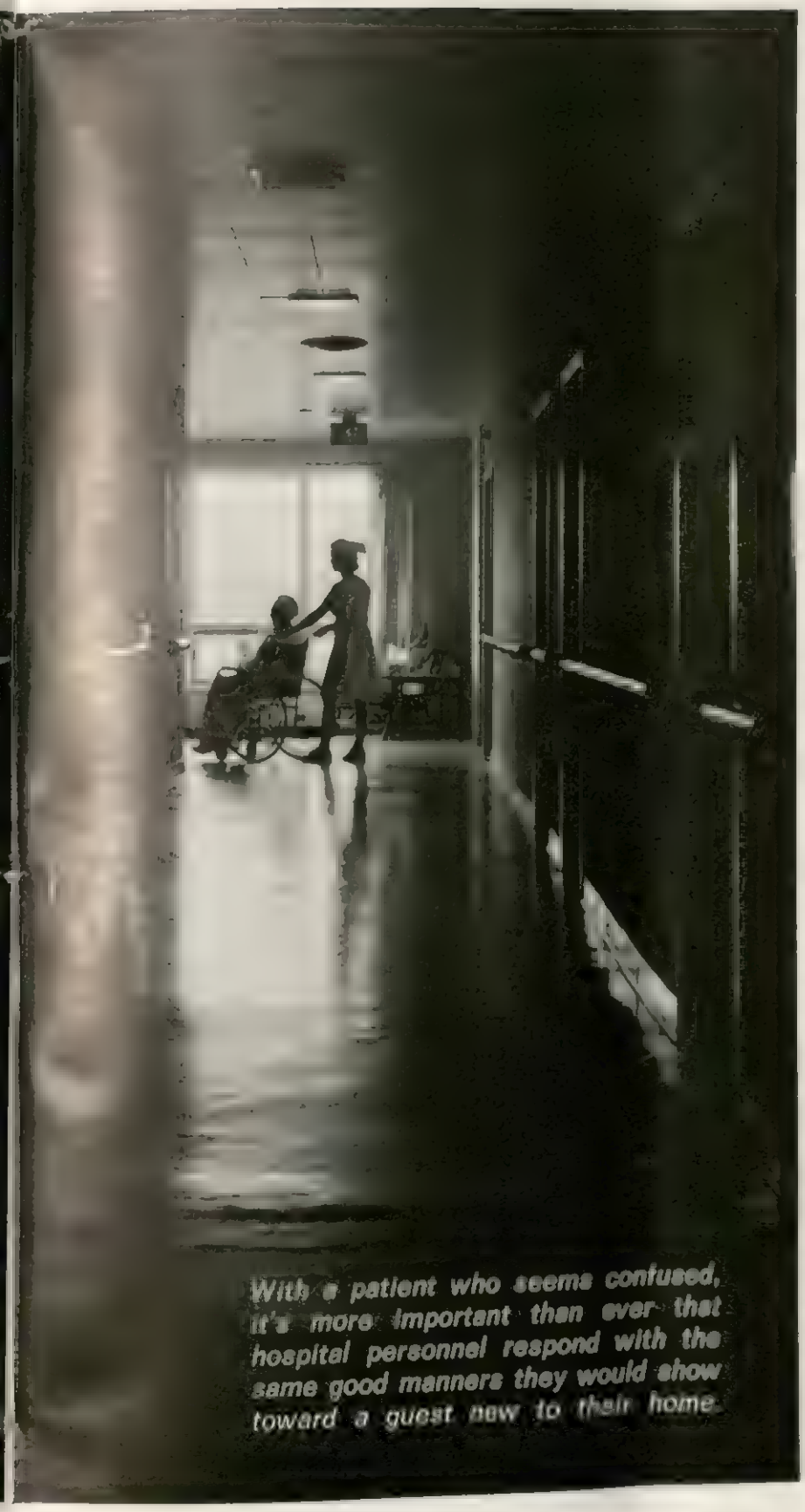
No one wants to bother him with facts for fear it might upset him. By this time the sedation is taking effect, and he drops off to sleep again. The same non-informative scene occurs for 2 days. By the time he wakes up in another strange room in the middle of the night, he is *truly* confused.

He awakens, sees someone standing over him with a pillow, and thinks he is being smothered. He begins struggling, and the sons are called in the middle of the night with the message: *Your father is combative, and we had to tie him down and heavily sedate him.* Because of his age, they also label him as *senile*, and no one expects him to recover from his confused state.

Fortunately, someone trained in the use of *reality orientation* (RO) intervened and instructed the family and the staff how to communicate with him. Doctors and nurses were instructed to call him by his name whenever they entered the room.

Also, the family was instructed to say, "Dad, I'm Jeff," instead of waiting for him to guess who they were. He was reminded where he was, what time it was, what day of the week it was. His wife showed him the paper each morning and pointed out the dateline, the weather report. He was reminded of the time of the next meal and of what was





With a patient who seems confused, it's more important than ever that hospital personnel respond with the same good manners they would show toward a guest new to their home.

going to be on the menu. Visitors and hospital personnel told him what they were going to do. If he was to be given medication, they informed him what it was and how it was going to be administered.

In a very short time, the confusion lifted and the impromptu diagnosis of senile was dropped. Now he was just a fine old gentleman recovering from a broken hip.

As simple as this sounds, there are some things that must be kept in mind if such an approach is to be successful.

For one, as a doctor, nurse, or aide, I should always be aware of how I may be affecting others. To me, the hospital, nursing home, or office is familiar and a part of me. I know the territory—I have no anxieties, because this is my terrain and my work.

On the other hand, the patient is insecure, afraid, apprehensive, and anxiety ridden. As a dependent person, he must place trust in others. Most patients do not think to question personnel in the helping professions. They may wonder what is happening to them, but they feel they have no right to ask questions or to query procedures. They are in unfamiliar territory and somewhat at the mercy of those who are taking care of them.

Therefore, it is more important than ever that these personnel behave with the same good manners as they would in entertaining a guest new to their home. In such a case, simple orienting instructions are usually given: *Here is the kitchen. If you get up early, the breakfast rolls are here, and the eggs are here. Your towels are on the rack nearest the lavatory. Here is your closet, etc.*

What is natural in our role at home should be as natural in any institutional setting. If it is unnatural and not practiced by staff, no techniques will focus staff attention so that it does become a natural way of communicating. You don't need any money to start such a treatment approach. But you do need time to train the staff.

The main thing the staff needs to know,
feel, understand, and practice
is open communication and teamwork.

One of the most popular diagnosis for confusion in the elderly is *cerebral arteriosclerosis with brain damage or organic brain syndrome or presenile dementia.* As soon as staff sees this diagnosis, they feel the situation is hopeless. Most untrained staff then proceed to *help* the patient to death.

There is a pervasive atmosphere of death in many nursing homes. Excuses are given that they are short-staffed and can't afford professionals who might start a program of meaningful activity such as learning self-care skills, helping each other, planning meals, being involved in the administration, etc.

Many administrators feel this is unnecessary, because they see their sole role as *taking good care* of the patients. Patients are protected for fear they might fall and hurt themselves. They are encouraged to stay in bed rather than wheel themselves to the bathroom or slide themselves to a potty chair. They soon learn that one can get attention by merely wetting the bed or behaving inappropriately in some other manner. Since they are expected to be confused and incompetent, they soon comply and reinforce the staff opinion that arteriosclerosis with brain damage is, indeed, untreatable.

These are just a few of the prevalent attitudes toward the aged who end up, for one reason or another, in some type of institution. These attitudes can be changed when staff sees a *return to reality* through the use of reality orientation. Once they see a patient overcome confusion and gain an interest in living again, the staff is rewarded for its effort. What had once been depressing and unrewarding work with terminal, regressed patients now becomes interesting and exciting as small gains are made and recoveries noted.

It is not simple to teach a staff any new technique or treatment approach. It would be simple if you had only to teach the surgeon, administrator, or nurse. With reality orientation, *everyone* needs to be taught.

If the day shift uses this approach, it will be lost if the night shift comes on and says, "Hi, Pop, how's my old Dad today?" What happens to *Pop* when he becomes restless at night, and no one is watching to see that he gets up and goes to the bathroom? The next morning the day shift reads *Pop wet his bed last night.* And so Pop is noted to have regressed.

With an untrained staff, this reinforces the idea of Pop as an untidy regressed, senile old man. He was dehumanized the first time someone addressed him that way, and the dehumanization continues until any identity and feelings of being an important and worthwhile person are lost. He then becomes just another *Pop, Grandpa,* or *Joe.*

Another concept that needs to be explored and given attention is the insight the staff has into its own behavior. What kind of kicks does an aide get from calling Mr. Atwell, *Pop* or *My little doll*? Or from saying *He really loves me better than he does his own daughter?*

The first two salutations are undignified and demoralizing to an older person. The person who is proudly proclaiming that the patient loves her is overlooking the hostility the patient is expressing for the daughter. These conflicts need to be worked through, not ignored. Staff need to understand that at times when they are *loved* or *hated,* it may have nothing to do with them personally. This makes intense feelings much easier to work through and with.

Staff members need to understand the process of aging—to recognize some of the physical accompaniments and emotional conflicts of normal aging, and some of the part that anxiety can play when a person is placed in a nursing home. They also need to understand the feelings of the family so that they do not always only see the side of the poor patient who says he has been *thrown out* of his home.

The main thing the staff needs to know, feel, understand, and practice is open communication and teamwork. Without an open flow of communication—up, down, and laterally—and recognition of the fact that the aide who is with the patient 24 hours a day is the most vital part of the RO philosophy and treatment program, such a program cannot possibly hope to be successful.

The *team approach* has become a popular catchword in modern treatment. It is rare to find a group of people working together in a true team approach. Essentially, this approach is nothing more than participatory management—everyone works and gets a share of the profits. Instead of sharing monetary profits, the team in this case shares the success of seeing a patient come out of confusion and a *hopeless* diagnosis.

If the aide is truly permitted to have a voice in decision making regarding treatment, he will work hard and be involved enough to see that suggestions work. Instead of

> The patient should be an integral part of the team as soon as he is able to participate in the daily activities of living.

passing orders down from the administrator or the professionals, input from those most intimately connected with the patient is considered for treatment decisions.

The patient, too, should be an integral part of the team as soon as he is able to participate in the daily activities of living. When the patient is ready to go home, that decision should involve him as well as his family and the institution.

In addition to reality orientation and the team approach to treatment of the confused person, another technique of communication called *attitude therapy* is important in helping promote a consistent therapeutic environment. Essentially, this dynamically based behavior modification system provides a way for staff to respond to certain types of undesirable behavior. One short case history here will illustrate the use of all three techniques.

Miss Walters entered a state hospital, because she was found wandering on the streets of a small Missouri town. She had been a very successful businesswomen but had retired 3 years before this episode.

She had come from Chicago, where she lived alone, to settle an estate. She and a family member had had conflicts throughout their life, and the settling of the estate opened old wounds. The town was strange, and there were no familiar landmarks. Staying at a small hotel, she began to show slight signs of confusion but refused to stay with relatives.

As Miss Walters grew progressively worse, the relatives, in desperation, brought her to the state hospital. On admittance, she was quite confused, hostile, and had let her physical appearance deteriorate.

Because of her hostility, the staff decided to approach Miss Walters only when she so indicated. They said, in essence, "We will all be passively friendly with her, so we do not frighten her." When she began rambling about being in Chicago, they told her matter-of-factly she was in a Missouri state hospital. No one begged her to do anything.

It was the staff's music therapist who first broke through to Miss Walters. The first time S. saw her she merely mentioned that there would be a song-session that day—part of a three-times-a-week program. Miss Walters said, "I don't care to sing today or any other day." S. walked on by without comment. She then observed Miss Walters during the group *sing*—sitting alone and showing little response. Despite this, S. felt the patient was quite aware of what was going on. S. noticed, among other things, that Miss Walters was always in the room while she was in that area. She seemed to enjoy the music therapist's antics with other patients and on the third session was keeping time to the music with her foot.

From the 24-hour-a-day RO approach, the staff leaving her alone when she so indicated and a consistent environment, Miss Walters showed rapid improvement. On the fourth day she was waiting for S. when she walked in. The therapist then very matter-of-factly said, "You owe me one hour of singing." Miss Walters laughed and joined the group. By the sixth session she was singing with the group, and by the eighth session she was helping S. gather other patients into the group.

The point here is that no one person can act alone. Without an administration that sanctioned the use of all personnel as treatment persons, this could never have happened.

If any staff member had crowded this woman, she would have become combative, and a vicious cycle would have been set up—completely detrimental to any improvement. If one of the aides had enjoyed listening to her rambling, she would have been reinforced for inappropriate behavior. If the doctor had tried to get close to her in a small room, she would have panicked. If the music therapist had insisted she sing, it would have ruined any gains made in her progress for that day.

With all of the staff working together—exchanging observations and information—signals were kept straight, and she was given the environment we felt she needed. As Miss Walters became less and less confused, and began to reach out, we changed the attitude therapy to a matter-of-fact approach. In this way, we reacted to her in much the same way we reach out to each other—a give-and-take relationship.

Reality orientation, attitude therapy, and the team approach are all systems of communication—open communication in a climate where everyone respects the contributions of all staff and of the patients. In this way, everyone has a stake in the treatment program, and they work together in a climate that can only promote good mental health. Such systems of communication are not appropriate for every situation but for helping people with communication problems, they can be tremendously effective. ■

THE CHALLENGE IT MEANS GROWING UP

Today, more than a fifth of men and more than two-fifths of women reach 80 years of age, with a sizable proportion living well into the ninth and tenth decades of life. At the same time, there is a growing tendency for people to retire (often involuntarily) from active, remunerative employment at ages younger than 65. It is not difficult to imagine the emotional response of such individuals as they ambivalently contemplate a period ahead of probable unemployment sometimes as long as, or longer than, the years of self-support behind them.

At the very least, such people are uneasy over what lies ahead. In an economic experience where cost of living and income are practically at parity, it is very likely that the aging have not been able—no matter how hard they tried—to accumulate a nestegg that will sustain them unaided through 15 to 25 years more of life. Chances are, that even though they have been independent, active, aware, cautious, prudent, wise and judicious, the prospect of having sooner or later to depend upon the generosity and interest of other people, or of governmental agencies, will present a depressing outlook.

It would be no surprise, then, if they were to grow increasingly less sure of themselves, to feel that they are becoming useless and in the way, to begin to falter in their judgments, to become forgetful, and to live in the memory of happier by-gone times.

That is the plight of millions of men and women today and many more in the future unless we as a nation apply more assiduously what we already know. Let us examine some of what we know.

The average age of all adults over 21 in our country today is over 45 years—an age wherein employers are still reluctant to some extent to hire men or women over 35. This means that more than half of American adults are in an age period in which employment discrimination is practiced despite new laws striving to increase employment fairness.

The aged segment of our population has increased over four times in the past century, with most of the increase having taken place in the last 50 years. The 65-and-over category grows at an annual rate of over half a million. In a quarter century, by the year 2000, statistical predictions indicate the older segment of citizens will number perhaps 35 million and constitute about one-eighth of the total population.

In our society, which has some social provisions for governmental support of the aged, we find that the ratio between non-workers and workers is increasing in the older age group. This may well mean that a progressively smaller number of younger people will shoulder a progressively larger tax burden to help support the non-self-supporting aged group.

Although human longevity is not increasing significantly, more people are reaching old age. Life expectancy at age 50 is 24 years. At age 65, a person has a better than average chance of living 12 more years. A 70-year-old may look forward to nine more birthdays. Many people born today will live to be 110!

The person of 50, 60, 70 and often beyond is healthier today than people of the same ages just 50 to 60 years ago. There are fewer residuals of childhood diseases today to mar old age. Our standards of living, housing, clothing, and diet are better than in the past. Improved health care, preventive medicine, health education, and public health activities have made significant contributions. Actual work records show that older people have fewer accidents, show less absenteeism, produce less waste, and are more loyal than younger employees. Why, then, are such large numbers of late mature people unhappy, dissatisfied and complaining?

One answer may well be found in the fact that due to popular prejudice and cultural attitudes our older citizens are still needlessly frustrated, excluded to some extent from social participation, and are often tolerated rather than welcomed. Frequently, their talents go untapped, their abilities unused, and their contributions unappreciated.

An analysis of popular attitudes suggests two outstanding deficiencies in prevailing thought:

Dr. Linden is Clinical Associate Professor of Psychiatry and Human Behavior, Jefferson Medical College and Chief of Older Adult Services, Jefferson Community Mental Health-Mental Retardation Center of Thomas Jefferson University, Philadelphia, Pa.

- Cultural strivings and values as they now exist appear to place a heavy emphasis on youthful points of view.
- Growing older seems generally looked upon as mental decline rather than development.

Let us consider the second viewpoint first. If one assumes that aging is paralleled by decline, then the questions must be answered: what declines? and when? A generalized, indiscriminate decline as a popular notion is nonsensical, because the individual and his faculties are not a mass of qualities all having the same rate of development, the same moment of achieving prime, and the same rate of declining. On the contrary, an individual's mental, emotional, and behavioral growth consists of countless separate trends—each having its own rate of development and role in human action.

We can illustrate this with some selected faculties that have already been studied carefully and subjected to statistical evaluation. Take, for example, the sense of hearing. It reaches its peak acuity at age 20 more or less and then diminishes with aging. In the field of vision, such abilities as quickness of visual perception, contrast sensitivity, and flicker-fusion sensitivity show a variable peak development around the ages of 25-30, then diminish with aging. In the field of motor response, we find a peak of proficiency between ages 40-50 followed by a decline. Reaction time in motor response shows peak development at age 17 followed by decline.

Intelligence tests show a decline in average scores in the twenties with a peak development around age 25-30. But subsequent losses are small, if at all, in such test items as vocabulary, information, and similarities. Greater decline appears to take place in such items as performance and certain problem-solving tests as numerical computation, commonsense, opposites, series completion, picture arrangement, digit symbols, and analogies. But all test-givers and devisers agree that tests now available, despite much recent research, still tend generally to fail in allowing for the *increased knowledge* and *experience* of elderly people.

It has been found that vocabulary and the ability to define words increase to age 60-69. This, of course, indicates an increase in conceptual thinking. The conclusion is drawn in factor-correlation tests that with increasing age, there is apparently an increase in *specificity* of performance. Tests evaluating learning and memory show that the magnitude of the loss depends on the nature of the test material—the least occurs with visual memory of digits; the greatest, with Turkish-English vocabulary transposition items.

Studies of intellectual functioning reveal that significant contributions in chemistry, physics, biology, and medicine are made less frequently after age 60. But leaders in the fields of legislation, jurisprudence, diplomacy, military and naval strategy, religion, and education are significantly older. Out of 2,607 scientists, it was found that most made their major contribution between the ages of 30 and 70, with a mean of about 40. It is not unimportant that 20 of these savants realized their major achievement after age 70.

The area of human attitudes and interests shows other important factors. Popular prejudice now holds that there is an increase in conservatism and a restriction in interests in older people. However, carefully controlled studies of comparable groups of younger and older people failed to show any significant difference in conservatism on an attitudinal scale. Even more contributory was a test situation to alter opinion. Here, observed changes in the younger testees were probably due to acceptance of statements by older authorities.

Human adjustment on personal and social scales also has been studied. One group of 2,000 office patients ranging in age from 10 to 90 were evaluated by clinical impression and a questionnaire. These failed to show any significant shifts in *emotionality* or *instability* in the older subjects. Investigators have been unable to prove any increase in neuroticism or poor personal adjustment with increasing age at least up to about 60. Other studies also suggest that in later senescence, such factors as economic security, late retirement, congenial housing and living arrangements, family support and affection, are important for good adjustment.

Now we must ask the question: when is a person old? Here, we are

continued

...OF AGING ...NOT DOWN

By Maurice E. Linden, M.D.

confronted with the problem of enunciating criteria of aging. If we use the dissected segments of human behavior, then a person's vision is growing old after age 25, but he is still young in motor response. Or he is aging in hearing acuity after age 20, but he is an infant in comprehension of government. His intelligence by circumscribed tests is declining after 30, but he is just developing his concept thinking. We can say that at 25 a person is too old to compete successfully in a cross-country foot race, but he is young in vocabulary, information, and specifity of performance. Furthermore, we have seen that age alone is no deterrent to social contribution in any sphere of mental activity.

It would appear that current attitudes relative to aging can be reduced to absurdities for one obvious reason: the values of comparison are ambiguous, too isolated, and biased. Any effort to understand human behavior must consider the total person and must relate him to the society in which he lives. It is in this realization that we find the clues for further consideration.

For purposes of simplification, let us divide the human life span into halves. We may coin the word *evolescence* to represent the first half. The word *senescence*, then, will represent the second half. We may further economize by referring to the E half (evolescence) and the S half (senescence). This simple maneuver yields an interesting discovery.

The S and E segments of our society do not appear to be in harmony with one another, each apparently having different value systems. An E rebellion against the S viewpoint is seen as a defiant attitude, continuous strivings to effect social change, repetitive cries for individualized expression, and a search for new truths (anti-establishment). The S's are in what appears to be sustained counterrebellion as seen in restatements of old ideals, a tenacity to established cultural dogma, reluctance to countenance social revolution, and an increasing reliance on past values as instruments of judgment.

Study of the S and E segments of society suggests that the E's are self-centered, pleasure seeking and concerned with a narrow social outlook, and more related to self-gratification in the long run than benefiting society. In contrast, the S individuals have a broader social outlook, are more altruistic, more protective of the E's, and more earnestly and consistently dedicated to preserving the indispensable mores of mankind.

This cultural *civil war*, however, is not an evenly matched conflict. It appears heavily weighted on the side of the E contestants (half of Americans are under age 30). Careful observation may disclose evidence that ours is an E-dominated society. We see this in the heavy emphasis that is placed on the attributes of youthfulness, physical agility, and reproductiveness. S values are overlooked, with the result that middle life and its associated changes are viewed as a climax implying subsequent deterioration.

This is probably a social error and is doubtlessly related to the dominant attitude that procreation is *the* function of the adult stage of living things. This means that life after reproduction is anticlimatic, that living long after reproduction means living beyond usefulness. Thus, fundamental quality of human adult life is neglected—that man differs from most other animals essentially by virtue of the fact that the continuation of his civilization depends upon acquired experience and the post-natal transmission of culture.

This implies a post reproductive usefulness in the human organism. The realization must become clear that the functions of preserving culture, of maintaining the annals of history, of keeping alive human judgment, of perpetuating skills, of conserving the tools of civilization, and of conveying all this to oncoming generations are the post-reproductive work of the human organism. Viewed in this light, senescence may be seen to uncover or develop a realistic and valuable quality of the human mind.

But the E point of view, being egocentric, tends to overestimate its own values. Such overdetermined E values may be agility and movement quantitative productiveness, ostentatious sexual attractiveness, and competitive cleverness. Such values contrast strikingly with S values that reveal a greater emphasis on deliberation, caution, quality, modesty and loyalty.

Age alone is no deterrent to social contribution in any sphere of mental activity.

The point here is that isolated fragments of human behavior cannot be regarded as adequate criteria for measuring an individual's progress through life. On the contrary, the person must be viewed as a total unit—a complete entity or social whole. This approach may aid us in discovering that the individual does not go forward to a point of prime achievement with subsequent decline, but rather that personality is a series of peak achievements.

The mental development of senescence, then, must be related to the post-reproductive functioning of the individual. Since the main S values are concerned intimately with the conservation of culture, then we ought to be able to comprehend human development as the measure of social outlook. This furnishes us a hint as to the real nature of personality maturation. The forward course of individual progress must be seen as the personality's continuous repudiation of its own infantile attitudes with the growing

acquisition of a cultural vista. This may be labeled *the psycho-social evolution of personality.*

Infancy as a beginning in life, is characterized by dominance of primitive strivings. In their pristine form, these urges—often referred to as instinctual—are unbridled but modifiable. That they become modified is a tribute to the relationship between the infant and its earliest environment. It is in the association and group life between the infant and his mother-environment, then the parental team, then the family, that the infant discovers that his primary wish to please only himself meets with continuous disapproval.

In order to achieve some harmony with his environment, he educates his primitive drives to coincide as well as possible with environmental demands. In this way, he undergoes progressive *social learning*, increasingly renounces pure instinct satisfaction, and tries to accomplish deeds of mastery that will win him plaudits and love from his milieu. This is an upgrowth of social attitudes with diminishing selfishness. The process is interrupted by puberty—a biologically impelled anatomic and physiologic process that is accompanied by a temporary and intermittent return to infantile needs and related egocentric attitudes.

The successful resolution of problems of puberty leads to further personality solidification, with the emergence of a more definite self-identity and accompanying early parent-like attitudes. Here, the boy begins to feel manly, sexually aggressive and protective, while the girl begins to feel womanly, thinks of motherhood, and dreams of family creation. The process leads to *pairing*—the characteristic dating of adolescence. It is in such pairing that youngsters discover their individual incompleteness and recognize their needs for cooperation between the sexes. Such attitudes, accompanied by developing an appropriate goal and mission in life, relate to the smallest possible social

continued

unit—a group of two people of opposite sexes.

The capacity for intimacy coupled with private needs for pleasurable instinct-gratification leads to the *mating* and reproduction of young adulthood. These are the beginnings of larger group formations—a *family creative* period.

A next stage of maturation may be discerned, a *social creative* period, in which offspring are undergoing earlier phases of evolescent maturation and in which parental attention is directed toward integrating offspring wishes with social requirements. The social development of the family and of the community collective of families becomes the central feature.

The physiologic upheaval of *change-of-life* (female) and *climacterium* (male) interrupts middle maturity and is usually followed by personality reintegration and later maturity, the latter seen as three sequential phases of development. By this time of maturity the progeny have usually reached an early adult level and are themselves in a family creative period. A governing and protective leadership befalls the mature adult at this stage as he assumes his sovereign position of ordering, overseeing, and maintaining his family of families. This period of later maturity may be termed *state creative*, because the scope of social vision at this level is wide and embraces a large society (the state).

The ordering of a state requires the establishment of social, moral, and ethical standards. To effect pacific relationships among the oncoming generations, the late mature parental body at this regulative level in the life cycle draws upon cumulative experience and renders decisions, assists in planning, erects social guideposts, and selects subordinate leaders. Since cultural standards are largely established and have endured the test of ages-old application, the mature mind rediscovers old values already found effective in civilized existence. Thus, the second segment of later maturity may be termed a *moral and ethical reaffirmative* period.

The last phase of late maturity is characterized by a profound concern for system, order, and meaning in human existence. The need to correlate the present with the past in order to determine the true nature of wisdom brings forward cultural vision at its broadest possible development, for here one nearly complete life and its relatedness to a multitude of other lives is available for critical evaluation. This third phase, then becomes one of *retrospective examination* and an increased interest in human developmental history may be found here.

While the younger person apparently perceives himself as a potential, dauntless and victorious master over a vaguely conceived mankind, the late mature senescent has mellowed to a level of earnest humility wherein he views himself as, at most, a contributor or at least a participant in an ordered civilization.

The foregoing consists of real and ideal stages of maturation in a theoretically normal personality. While such stages can be seen in the maturing individual, the argument is offered that they do not receive their deserved value in our society, which often seems monopolized by immature values. In a society that emphasizes youth, the later mature person represents loss of youth. Where physical power is glorified, the mature person is a physical weakling. Where youth perpetually struggles against and defies cultural code, the mature person stands as the champion of system and order. Where competitiveness, shrewdness and intrigue are youthful ideals, the senescent is an advocate of wisdom, deliberation and caution. Where the evolescent stresses mass production, stupendous accomplishment and change, the mature person places greater value on detail, quality and stability. And where youth loves life, vigor and freshness, the late senescent stands as a reminder of death.

A latent attitude of disdain for age is implanted in the evoles[illegible] who scorns senescence. How[illegible], as this individual progresses [illegible] senescence, he may well becon[illegible] victim of his own latent attitu[illegible] In other words, in a culture cha[illegible]acterized by evolescent attitu[illegible], the S person expects to be sco[illegible] and excluded and to some e[illegible] rejects himself.

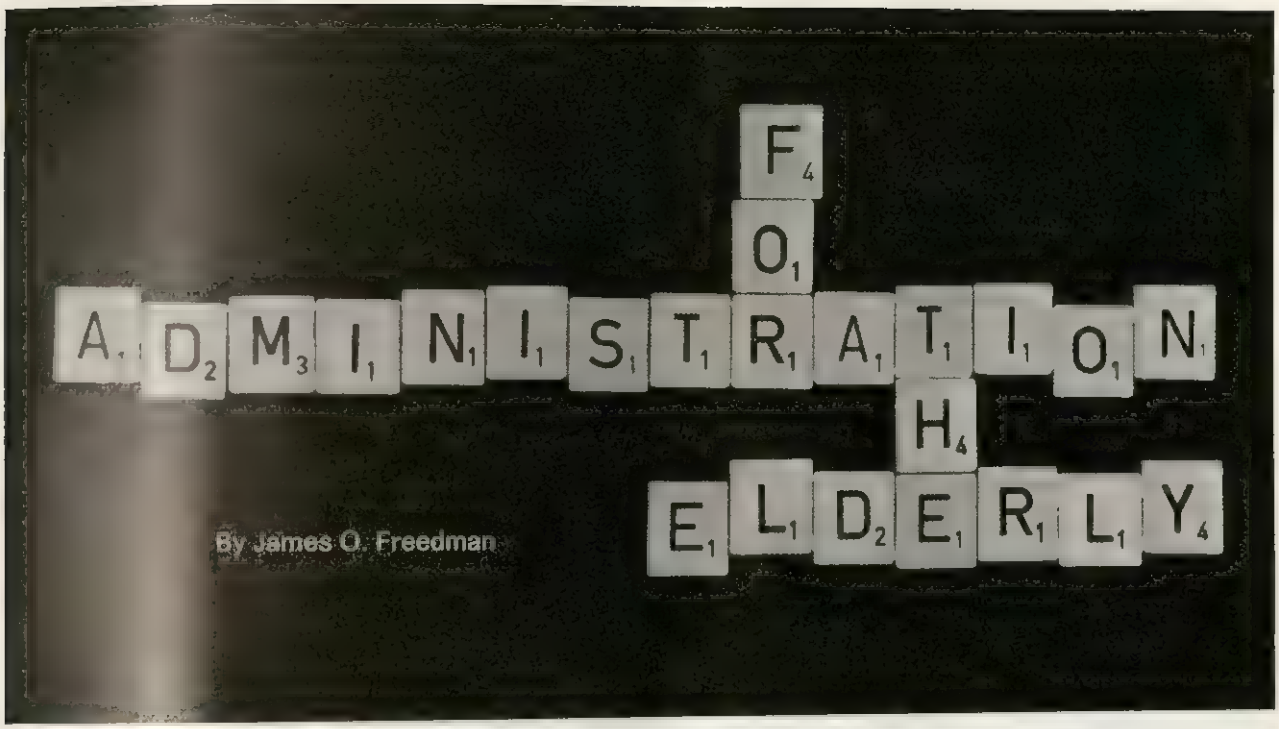
Our society may present a d[illegible] rejection toward the aged—a cultural exclusion (he is outnumbered) and a self-rejection. Shoved to[illegible] wayside, isolated and often [illegible]

Our society may present a double rejection toward the aged—a cultural exclusion and a self rejection.

glected, it is only logical for th[illegible] excluded person to question hi[illegible] own worth. As the feeling of useful[illegible]ness is diminished, self-esteem low[illegible]ered and the sense of security threatened, there ensues a loss of some of the most effective personality defenses—and the *senile condition* is ushered in with the entire syndrome of suffering: fatigue, anxiety, perplexity, confusion, altered alertness, memory impairment, and mood changes all overlain with a depressive view of reality.

A large part of commonly witnessed so-called senility is of psychological origin. Death as the logical outcome of life need not be prefaced by catastrophic decline.

Increasing understanding of the real capacities and needs of older people has led to very effective methods of therapy and care. It is axiomatic that what is treatable is also preventable. The need for preventive mental health conceptualization in our systems of living into the later years recommends itself. ■



How can the administrative process be used most creatively in achieving the Nation's public policy for the elderly? Is there reason to believe that this policy can be carried out efficiently by the administrative process when administrative agencies have consistently been criticized for failures of the most fundamental kind? What, indeed, are the effective limits of the administrative process in providing programs and services for the elderly?

These questions are central to an understanding of the limitations and possibilities of relying upon the administrative process to improve the situation of the elderly, to increase their dignity as human beings, and to enlarge the bounds of their participation in American life.

The United States has a long tradition of relying upon the administrative process to secure newly defined rights and to achieve newly endorsed goals. Following the Revolutionary War, administrative agencies were created to adjudicate the claims of veterans and their widows, collect the customs, determine patent rights, govern Indian affairs, and supervise land grants. These early agencies gave promise of an expertise and a specialization, of an informality and an expedition, that were urgently required in the solution of national problems.

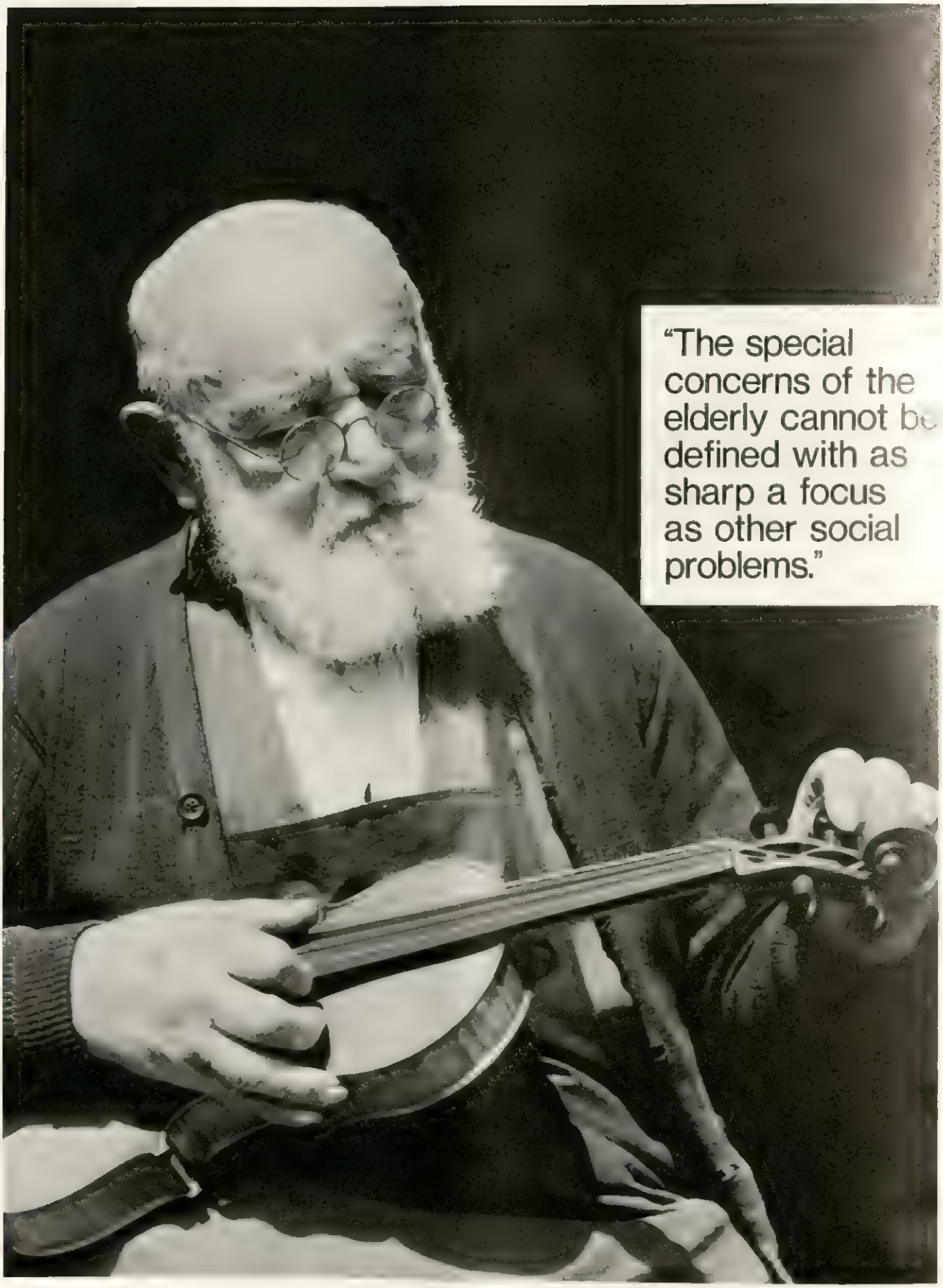
The tendency to resort to the administrative process for the practical solution of national problems was, of course, greatly accelerated during the New Deal years, when the National Labor Relations Board, the Securities and Exchange Commission, the Civil Aeronautics Board, and scores of other agencies were brought into being. The tendency has continued undiminished to the present day, under liberal and conservative Presidents alike. Administrative agencies now have a pervasive impact upon American life.

To protect the rights and improve the situation of the elderly, a number of programs are entrusted to various administrative agencies. For instance, the Department of Health, Education, and Welfare administers the Older Americans Act, which encourages the states to provide programs and services for the elderly; and the Social Security Act, which provides benefits to the elderly under both the old age, survivors and disability program and the medicare program. The Department of Labor administers the Age Discrimination in Employment Act, which prohibits employers, labor unions, and employment agencies from discriminating on the basis of age against persons. The Commissioner of Internal Revenue administers the pension plan provisions of the Internal Revenue Code, which provide tax advantages to employers who create pension plans that benefit their employees in ways that Congress has prescribed.

In addition, many administrative agencies have the capacity to affect important concerns of the elderly, even though the statutes they administer are general in scope and were not enacted primarily to benefit the elderly. When the Federal Trade Commission, for example, orders a respondent to stop advertising a product in a deceptive man-

Mr. Freedman is Professor of Law at the University of Pennsylvania and Immediate Past President of the Mental Health Association of Southeastern Pennsylvania.

This article was adapted from one previously published in the Temple Law Quarterly.


"The special concerns of the elderly cannot be defined with as sharp a focus as other social problems."

ner—the famous Geritol case is an illustration—the decision protects prospective purchasers who are elderly, although its total impact is quite obviously more general.

As a general rule, administrative agencies can be described as passing through several stages of existence. They are usually born amid high hopes that government has, at last, taken effective action in creating a new mechanism to carry out the Nation's goals in an area requiring dedicated attention. The same agencies come to adolescence amid charges that they have begun to lose their former sense of mission and vitality, that they have become complacent and tired. The problems within their jurisdiction often prove more intractable than anticipated and the task of continually confronting resistant social phenomena becomes increasingly frustrating, particularly when an agency has achieved earlier successes. Administrative agencies then enter maturity, a period in which their processes become institutionally routinized and they appear to place greater importance upon conformity to bureaucratic norms than upon innovative achievements.

The reasons that cause administrative agencies to pass through this progression are, of course, complex. The social conditions that give the agencies their initial momentum tend to change their shape—often precisely because of the agency's effectiveness in confronting them—and the necessity for acting with urgency and imagination becomes relaxed. Moreover, the problems that remain after years of agency efforts are often the most difficult to contend with, because they are the most sensitive and intractable.

In addition, as the layers of an agency's internal bureaucracy multiply, as the number of its field offices grows, as the multitude of private groups with which it must cooperate increases, as the men at the top find each successive enforcement effort less challenging and less exciting than the one that came before, as prudence becomes increasingly necessary if the agency is to survive the resentment and political repercussions that energetic enforcement typically engenders, the ability of an administrative agency to maintain its initial level of creativity and enthusiasm gradually diminishes.

A second tendency of administrative agencies is that of becoming unduly oriented toward the groups they were created to regulate. Critics will often argue that the regulated industry has *captured* a particular agency, that *administrative action reflects predominately the solution desired by the industrial group.*

The fact that there should sometimes be a basis for such a charge is hardly surprising, given the facts that administrative agencies and those whom they regulate have certain kinds of advantages each over the other, that employment opportunities generally move from both agency to industry and industry to agency, that long-term dealing with the problems of an industry inevitably leads to a greater sympathy and understanding for the industry's attitudes, and that living on terms of harmony with one's formal adversary is, for many regulators, a more comfortable way of professional life than engaging in perpetual combat, however sublimated it may be beneath the forms of legal actions.

These two tendencies—toward *bureaucratic ossification* and *industry orientation*—are not easily overcome, as more than one disillusioned agency chairman, present and past, could attest. But means of reducing their force exist and merit the serious consideration of those who would make the administrative process more effectively serve the interest of the elderly.

First, careful thought should be given to placing new programs involving the elderly under the jurisdiction of newly created administrative agencies, as Congress did when it concluded that environmental spoilage required increased Federal attention from an Environmental Protection Agency, rather than under the jurisdiction of existing agencies.

Newly created agencies, freshly charged with a mandate to get a job done well, typically act with energy and imagination during their early years. The vigorous performance of the Environmental Protection Agency suggests the capacity of newly created agencies to take decisive action in a manner quite inconsistent with patterns of bureaucratic ossification or industry orientation. It is not clear that the Environmental Protection Act would have been implemented as decisively had responsibility for its administration been placed in an existing agency, with its inevitable web of relationships to the industries under its jurisdiction.

By creating new administrative agencies to carry out new national programs for the elderly, Congress can avoid some of the institutional problems presented by reliance upon established agencies and can gain a heightened visibility and separate identity for these programs. The difficulty, of course, is that newly created administrative agencies eventually become established administrative agencies, and the day of reckoning has only been postponed. The test of the Environmental Protection Agency will be whether it can maintain its momentum over the long term of years, as the enthusiasm of its recently recruited staff gives way to increasing frustration and as the power of the regulated industries makes itself felt, politically and otherwise.

It must be recognized, however, that creating new agencies to administer programs of concern to the elderly will not always be practical.

continued

The special concerns of the elderly cannot be defined with as sharp a focus as other social problems, such as environmental spoilage. The concerns of the elderly are not only much more diffuse, they are also often the subject of administrative programs that have a more extensive reach—such as tax treatment of pension plans, which itself is part of a tax structure seeking broader goals of income distribution.

Frequently, then, it will be impractical to separate programs affecting the elderly from the broader regulatory context of which they are a part. In addition, a decision to create a new administrative agency rather than to rely upon an established one may require the sacrifice of valuable regulatory experience, including an extensive knowledge of specific industries, particularly when the new legislative program is closely allied in character to programs administered by existing agencies.

Finally, newly created agencies may sometimes be more vulnerable to industry *capture* than newly created programs placed in established agencies. Thus, a Task Force on Medicaid and Related Programs of the Department of Health, Education, and Welfare in 1970 recommended against creation of a separate Department of Health because it *would be a prime target for "capture" by powerful special interest groups*, and added that *as part of a larger agency, health activities are frequently subjected to close scrutiny and countervailing forces which can act as a shield against power interest groups.*

Second, careful attention should be given to the quality of the individuals appointed by the President as chairmen of administrative agencies that have responsibilities with significant implications for the elderly. The chairman of an administrative agency can make a striking difference in the way in which the agency conceives its function, defines its ambitions, and performs its duties. As James M. Landis wrote in his report to President-elect Kennedy, *Good men can make poor laws workable; poor men will wreak havoc with good laws.*

However, one ought not romanticize the power of an agency chairman to lead his agency in the directions he desires. His fellow commissioners may oppose his substantive initiatives or be indifferent to his sense of urgency. Also the agency's staff of career professionals may regard the current chairman as no more than a temporary policymaker who will stay for a brief period and then move on, as so many others before him did. If a chairman is to make a difference in these circumstances, he must be an individual of unusual ability and personal and intellectual force.

Those who are concerned with the capacity of the administrative process to serve the needs of the elderly could usefully begin by asking whether the administration of programs concerning the elderly should be given to newly created administrative agencies or placed under the jurisdiction of established agencies. Moreover, they could direct attention to the importance of appointing qualified individuals to positions of high responsibility in administrative agencies that enforce public policy toward the elderly.

Let's now turn to some particular ways in which administrative agencies can make creative use of their authority to affect the quality of life of the elderly.

To begin with, more than 90 percent of the actions of Federal administrative agencies are taken informally, without a hearing. One of the most important of these actions is deciding which cases to prosecute —to bring to formal proceedings— and which not. This power, with its enormous implications for selective enforcement of the law, is almost wholly discretionary.

The Federal Trade Commission, for example, has authority to bring proceedings against those engaging in unfair and deceptive trade practices in interstate commerce, a mandate of extensive breadth. Given its limited staff and budget, the Commission can invoke this authority only selectively. It could significantly serve the interests of the elderly by devoting an appropriate amount of time and prosecuting resources to practices and products of particular concern to the elderly—such as hearing aids, patent medicines for such ills as arthritis and irregularity, real estate promotions for retirement homes in sunny climates, and home repair services.

Greater administrative attention to products such as these, which concern large numbers of Americans, is not inconsistent with the Commission's basic statutory responsibilities. In this sense, proceedings that benefit the elderly are no different from proceedings brought by the Commission that may benefit one group in society somewhat more than other groups. Of course, the elderly have no special claim to disproportionate attention from the Commission or from any administrative agency with a mandate to protect *the public interest*. But administrative agencies, as a matter of discretion, may appropriately accord to the interests of the elderly a degree of prosecutory attention commensurate with the considerable proportion of the population they comprise.

Citizen groups concerned with the quality of life of the elderly could perform a useful public function by monitoring the activities of administrative agencies and publishing analyses of the choices that particular agencies have made in allocating their enforcement and supervisory resources. These analyses could provide a basis for public discussion of the wisdom of these choices. They might also lead to greater sensitivity on the part of administrative agencies to regulatory concerns of special significance to the elderly.

A possible device to facilitate the effective participation of the elderly in the administrative process might be designed along the lines of a provision in the National Environmental Policy Act of 1969. This provision requires Federal administrative agencies to issue an impact statement whenever a proposed action will significantly affect the

quality of the human environment. If agencies issued explanatory statements describing the possible impact upon the elderly of the actions they proposed, those concerned would receive more notice than they often do now. They would then be able to decide whether to seek to participate in the agency proceedings.

These suggestions are designed to make administrative agencies more conscious of the impact of their actions, both formal and informal, upon the elderly. For such suggestions to be successfully implemented, those concerned with the impact of public policy administration upon the elderly will have to organize groups that will seek vigorous participation in the administrative process. Participation in the administrative process—no less than in the political process, where it has older antecedents—can be an efficient vehicle for achieving a group's goals.

Thus, groups representing the concerns of the Nation's 20 million persons over 65 should be able to achieve a considerable level of visibility and success, as Sharon Curtin has recently suggested in her moving book, *Nobody Ever Died of Old Age*. More important, they should be able to make significant contributions to the process of rational and fair administrative decision making.

Group representation, whenever it is proposed, raises the unpleasant possibility of further fragmentation of the American community, in which the parochial interests of competing groups may replace a generous view of the community interest as the touchstone of advocacy and decision. But this prospect is surely overdrawn. Administrative agencies already listen to a wide spectrum of competing views. There is no reason why an administrative agency should lose sight of its statutory goals, because the elderly effectively advocate their views.

However, the participation of groups representing the elderly is a healthy prospect, which will expose administrative agencies to a useful diversity of new views. The elderly, after all, are probably as diverse as any other broadly defined section of the population: rich and poor, employed and unemployable, black and white, sick and healthy, educated and illiterate. No individual organization will be able to properly claim to speak for such a diverse group as this. Many groups—representing different and, perhaps, even conflicting interests of elderly persons—will doubtless be created, thereby sparing administrative agencies the unpleasant necessity of estimating the authenticity of groups claiming to speak for all of the elderly.

These, then, are some of the considerations that should guide an assessment of the effective limits to the capacity of the administrative process to achieve the Nation's public policy for the elderly. Such an assessment runs the risk of error, however, if it overlooks the significance of the national mood and spirit to the administration of any major governmental program. When social expectations for a governmental program are low or merely perfunctory, that program will not have the sustained political support necessary to permit it to be effective. This means that those concerned with creating conditions in which the administrative process can function effectively may have to pay considerable attention to the political process by which community standards are formed and sustained.

Finally, we must take special care, in placing the administrative process in the service of public policy for the elderly, to design programs that respect the elderly as individual human beings. As Lionel Trilling, one of our most perceptive social commentators, has written: *We must be aware of the dangers which lie in our most generous wishes. Some paradox of our nature leads us, when once we have made our fellow men the objects of our enlightened interests, to go on to make them the objects of our pity, then of our wisdom, ultimately of our coercion.* ■

"We must take special care . . . to design programs that respect the elderly as individual human beings."

BOOKS

Aging in America
Bert Kruger Smith
Boston: Beacon Press, 1973. 239 pp., $8.95.

The picture of the old woman on the dust jacket of the book is probably not that of the author. Nevertheless, it does convey the reflective, compassionate, intelligent and warm general attitude of this summary of some of the problems encountered by the elderly. It is so disarmingly and charmingly written that it avoids dryness, even in the concise presentation of statistical material. The author makes points about the heterogeneity of the aged in a poetic, touching, informative, and accurate manner.

As in most abbreviated summarizations, the sources quoted are usually secondary, and the original thinkers and researchers receive no credit. Consequently, it would be difficult to trace on the basis of the information given.

There is one relatively critical item about which the reader should be forewarned. In the discussion of institutions, the author makes the common error of confusing the long-term hospital schizophrenic with the truly senile person; that is, she gives an example of a *senile psychotic patient*, one who had been hospitalized for 58 years as having been hospitalized in old age. This is probably because of an unfortunate choice of source material, and here the blame may possibly be laid to psychiatrists who have permitted such misconceptions to come into their writing and planning.

The book contains nothing that the well-informed professional does not already know, but it can be useful to them as an organizing review. The book in its entirety, or in part, may be useful to instruct persons in any of the helping professions. It also may be especially valuable for persons with no scientific or technical background. The style is simple enough to be useful in teaching high school and college students as well as those interested in the statistical aspects of public health.

The book is small and compact, with relatively large and easily readable type. It has a good table of contents, a short helpful index, and also contains a chapter reviewing the 1971 White House Conference on Aging. It points clearly to its source and gives some information or resources or how information can be obtained from the Federal government and each state.

ALVIN I. GOLDFARB, M.D.
Associate Clinical Professo
of Psychiatry and Associate
Attending Psychiatrist in
Charge of Geriatric Servi
Mt. Sinai Medical School and
Hospital
New York, N.Y., 10029

Child Rorschach Responses
L. B. Ames, M. A. Métraux, J. L. Rodell, and R. N. Walker
New York: Brunner/Mazel, Inc., 1974. 321 pp., $12.50.

Twenty years separate the first and second editions of *Child Rorschach Responses*. Except for minor changes, the bulk of the current edition is essentially the same as the earlier book: a compact, skillfully presented analysis of 650 Rorschach records of children from ages 2 through 10. The book is written for the professional already familiar with Rorschach theory and scoring. Either edition is fascinating for advanced students of developmental psychology and is invaluable for clinicians working with children who need age norms to make more refined assessments of normal childhood development and its deviations.

One limitation of the first edition was that the norms reported were limited to the initial population studied —a group of children from the higher socioeconomic levels. The second edition presents comparative data on more diverse socioeconomic samples. Another major advance of this edition is the presentation of longitudinal data spanning the ages from 4 to 14.

Both of these additions represent impressive steps forward, but the amount of coverage given them serves more to whet the reader's appetite than to provide a comprehensive discussion of their implications. The same is true for the final, brief

chapter of the book in which research findings are presented to argue for using Rorschach test data to differentiate emotionally disturbed children from normals and to predict reading ability.

One significant advance that distinguishes this later edition is the presentation of longitudinal research. The sample size is small and again biased toward the upper socioeconomic levels. Nevertheless, one can begin to look at how a child's Rorschach dynamics change with age. Psychodynamic theory would predict that as a child gets older, his Rorschach data should reflect the gradual shift from primary to secondary thought processes. Thus, one would expect to find a progressive increase in the number of human movement responses and a corresponding decrease in color determined responses. Although the evidence presented is equivocal, there is a wealth of data to stimulate critical thinking.

Although the data from more diverse socioeconomic levels are not combined with the core sample of 650 children, comparative age norms are provided in the second edition. The overall trends of Rorschach variables across all socioeconomic levels follow a similar pattern. However, there are marked age-to-age variations in the developmental course of scoring criteria. This finding means that children of different ages, of different socioeconomic levels and, perhaps, different sexes may have different sets of Rorschach norms. The implications of this hypothesis for clinical assessment and research are enormous and deserve more attention than the authors give.

In conclusion, the second edition of *Child Rorschach Responses* makes its own contribution to the fields of child psychiatry and psychology. The reader unfamiliar with the earlier edition will find in this current work both a recapitulation of the core study, with some slight changes, and a brief account of the latest research efforts of the authors. The reader already familiar with the first edition, who would probably be more interested in the recent studies, may be disappointed at the limited coverage given to them.

ANDREW BURKA
Department of Psychology
University of Rochester
Rochester, N.Y. 14627

Adolescence: Psychology, Psychopathology and Psychotherapy
Derek Miller, M.D.
New York: Jason Aronson, 1974. 544 pp., $15.00.

This is a benchmark book. It points the way from the era of developmental-psychology-will-tell-us-how-to-help-kids to a new era that recognizes that developmental wisdom is not enough. Much of what is currently known about developmental psychology that can be helpful to parents, teachers, and health care professionals is covered. The physical, emotional, educational, and social needs of adolescence are presented in lengthy but easily digestible form. Extremely difficult and complex topics are walked through without polemics or hysteria. From anorexia, architecture, abortion and acne to vanity, violence, voyeurism and women's liberation, there are thoughtful comments for the newcomer.

Another plus—Miller offers no simple solutions to these complexities. This is pleasing to those not afflicted with the Ginott syndrome, but will be distressing to those looking for easy advice.

One is tempted to nit-pick. Could any of us write 500-plus pages on sex, drugs, education, poverty, race, and psychotherapy without leaving a trail of nits begging to be picked? Pickers are better advised to write their own books.

But why is developmental wisdom not enough? A new era of systems analysis is upon us. The author states repeatedly that we must in addition understand the *systems*—family, peer groups, school, culture. We must learn to speak in interactional terms of system functions; power distribution, affective interchange, feedback, and morphogenetic mysteries must be explored. Dr. Miller points the way, gently but insistently. There are those on that frontier who already know the material in this book and are going beyond. Their writings on adolescence, family, education and therapeutic intervention are coming.

JOHN T. GOSSETT, PH.D.
Research Psychologist
Timberlawn Foundation
Dallas, Tex. 75227

Pathological Behavior Disorders in Adolescents
Edited by A. E. Lichko
Leningrad: RSFSR Ministry of Public Health, 1973. 104 pp., $2.00.

During a recent visit to child and adolescent psychiatry facilities in Moscow and Leningrad, I was impressed by the familiarity of Russian child psychiatrists with Western professional literature. By comparison, American psychiatrists are almost totally unaware of Russian child psychiatry.

While Soviet psychiatry places emphasis on organic and constitutional factors, the Leningrad psychiatric school gives greater recognition to interpersonal and environmental influences and is, thus, more comparable to American psychiatry. Professor Lichko, a leading Russian adolescent psychiatrist, has edited this slim volume on adolescent psychiatry from the renowned Leningrad Bekhterev Psychoneurological Institute. Though the monograph is in Russian, the English chapter summaries will introduce the non-Russian reader to Soviet adolescent psychiatry.

In his introductory chapter, Lichko discusses normal adolescent emotional growth and the possible pathological deviations. While he emphasizes the emancipation strivings, the peer group formation and the channeling of *underdeveloped libido*, he also places marked emphasis on the development of *hobbies*.

These hobbies include the usual North American collecting hobbies but also involve intellectual, athletic, and leadership growth sublimations of adolescent energy. Contributed by other authors, the chapters in this book develop these themes of adolescent development and maldevelopment, focusing further on hobbies, emancipation strivings, relationships with parents, and different psychopathic characters. Two chapters, one on autistic syndromes in adolescents and the other on hyperthymic character accentuation, present concepts that are accepted in the Soviet Union but are relatively novel to American readers.

American child psychiatrists would productively learn a great deal from their Soviet counterparts. This small book can serve as an introduction to Russian adolescent psychiatry and hopefully lead the reader to learn further from his Soviet counterparts.

WILLIAM M. EASSON, M.D.
Professor and Chairman
Louisiana State Universi
Department of Psychiatr
New Orleans, La. 7011

Concerning Death:
A Practical Guide For The Living
Edited by Earl A. Grollman
Boston: Beacon Press, 1974. 365 pp., $7.50.

This collection of essays is well worth reading. Although varying greatly in style and length, each illuminates an aspect of death and the rituals that surround it. It is both practical and aimed at the living. Several of the essays had particular appeal for this reviewer.

Cassem's *Care of the Dying Person* offers sound practical advice, as does Grollman's *Children and Death*. Jordon, Butler, and Grollman share with the reader concise summaries of Protestant, Roman Catholic, and Jewish positions about death and the associated ceremonies in ways that appear helpful to individuals who are not members of those faiths. *The Law and Death* by Ross presents a succinct summary of the legal aspects, including estate taxes, while Irion's *To Cremate or Not* is of particular help in placing this process in its historical and cultural contexts.

There is increasing evidence that our culture's avoidance of death contributes to individual difficulty in dealing with loss. Difficulty in dealing with loss, in turn, is implicated as one etiological variable in both physical and mental illness. As a consequence, a number of helping disciplines have moved in the direction of breaking down the cultural conspiracy of avoidance. This collection of essays is a welcome addition to that force.

JERRY M. LEWIS, M.D.
Timberlawn Foundation
Dallas, Tex. 75227

Aging And Mental Health:
Positive Psychosocial Approaches
Robert N. Butler, M.D. and Myrna I. Lewis
St. Louis: The C. V. Mosby Company, 1973.
306 pp., $5.95.

In the *Dialogues of Plato*, Socrates poses the following question to Cephalus: "There is nothing I like better, Cephalus, than conversing with aged men, for I regard them as travelers who have gone a journey which I, too, may have to go, and of whom I ought to inquire whether the way is smooth and easy, or rugged and difficult. And this is a question I should like to ask of you who have arrived at that time which the poets call the *threshold of old age*. Is life harder towards the end, or what report do you give of it?"

Cephalus' reply can be summed up by his conviction that old age is not a disease and that man's character determines his view of and experiences with aging and his ability to cope with it.

Butler and Lewis—neither one of whom may be considered to be at the threshold of old age—have, nevertheless, all the sensitivity and understanding of the aged and have had the wisdom of *conversing with aged men* and, thus, provide us with a thorough *report of it*. They, as well as many of us involved in the field of aging, doggedly insist that old age is not a disease. It is that which befalls the elderly—the social, psychological, cultural and economic ambiance—the events of passing time which determine the vicissitudes that befall man as he proceeds in that relentless journey of time.

Ageism, the systematic stereotyping and discrimination against the elderly, plays as much of a role in the emotional problems of the aged as do some of the biological deficits that may accrue.

Butler and Lewis present us with an overview of the field—a textbook for all mental health workers with helpful, pragmatic prescriptions for the maintenance of mental health in late life. If one has any quarrel with them about the book, it would be their hortatory tone in many passages. But then they are eloquent, concerned advocates of the needs of the aged and are tillers in the vineyards of those who are ill. I recommend it highly as, indeed, I find it a unique text in the teaching of geriatric psychiatry.

JACK WEINBERG, M.D.
Illinois State Psychiatric Institute
Chicago, Ill. 60612

Poetry The Healer
Edited by Jack J. Leedy
Philadelphia: J.B. Lippincott Company, 1973.
220 pp., $8.95.

Poetry is believed to be a natural resource for healing toward which people intuitively turn. Both the reading and writing of poetry are included within the concept of its healing power. One does not have to be a poet to write poetry; it can be a powerful means of spontaneous self-expression for anyone.

Jack J. Leedy, poetry therapist and psychiatrist, has promoted the poetry therapy movement through his founding of and participation in various poetry therapy groups, to the extent that he could be considered an authority on the subject. Because of scant available literature on the subject, Leedy's first book, *Poetry Therapy* (J. B. Lippincott Co., 1969), contributed greatly to the knowledge and growth of this modality.

As a follow-up to that pioneer work, the present volume expands the scope of poetry therapy to include experience with prisoners, drug addicts, and deaf children. Following the method of his first book, Leedy asked a number of his colleagues to share their experiences with poetry as a therapeutic/healing force.

The potential uses of poetry appear vast, and the further exploration with this modality by Leedy and his colleagues are important and exciting. The book is well written and clearly presented so that both the layman and professional interested in poetry as a therapeutic/healing force will enjoy and find it worthwhile.

SHARON HENDERSON SCLABASSI, A.C.S.W., L.C.S.W.
Psychiatric Social Worker
San Jose Hospital
San Jose, Calif. 87565

PUBLICATIONS

To order, write NAMH Publications Dept., 1800 No. Kent. St., Arlington, Va. 22209

Policy and Position Statements (*Free on request*)

- ☐ ABORTION
- ☐ CHILD DEVELOPMENT CENTERS
- ☐ CIVIL RIGHTS OF MENTAL PATIENTS
- ☐ THE DISADVANTAGED
- ☐ FACILITIES AND SERVICES FOR THE GERIATRIC MENTAL PATIENT
- ☐ FAMILY LIFE AND SEX EDUCATION
- ☐ HOMOSEXUALITY
- ☐ HUMAN EXPERIMENTATION
- ☐ JOINT COMMISSION ON MENTAL HEALTH OF CHILDREN REPORT
- ☐ MANPOWER
- ☐ MARIJUANA
- ☐ MARRIAGE COUNSELORS
- ☐ MENTAL HOSPITAL/LABOR-MANAGEMENT DISPUTES
- ☐ MENTALLY ILL AND THE LAW
- ☐ NATIONAL HEALTH INSURANCE
- ☐ PASTORAL COUNSELING
- ☐ PSYCHOSURGERY
- ☐ RIGHT TO TREATMENT
- ☐ STANDARDS FOR LABOR PERFORMED BY STATE HOSPITAL MENTAL PATIENTS
- ☐ SUICIDE PREVENTION
- ☐ THIRD PARTY PAYMENTS FOR THERAPISTS

Pamphlets

- ☐ CAN MENTAL ILLNESS BE PREVENTED? $2.20 per C.
- ☐ CLERGYMAN'S GUIDE TO RECOGNIZING SERIOUS MENTAL ILLNESS. $10.00 per C.
- ☐ MINISTERING TO FAMILIES OF THE MENTALLY ILL. $10.00 per C.
- ☐ THE CLERGY AND MENTAL HEALTH. $10.00 per C.
- ☐ FACTS ABOUT MENTAL ILLNESS. $1.50 per C. Basic up-to-date statistics.
- ☐ FILM CATALOG. Free. Selected films for mental health education.
- ☐ GROWING UP AIN'T THAT EASY. $1.20 per C. Dos and Don'ts for dealing with the emotionally disturbed.
- ☐ HOW TO DEAL WITH YOUR TENSIONS. $7.50 per C.
- ☐ HOW TO INVOLVE ETHNIC MINORITIES AND THE POOR IN THE MENTAL HEALTH ASSOCIATION. $12.50 per C.
- ☐ INSURANCE IN MODERN MENTAL HEALTH CARE. $5.00 per C. Current thinking on insurance coverage for mental illness.
- ☐ CHILD ALONE IN NEED OF HELP. $2.30 per C.
- ☐ HOW TO DEAL WITH MENTAL PROBLEMS. $7.50 per C.
- ☐ HOW TO RECOGNIZE AND HANDLE ABNORMAL PEOPLE: A MANUAL FOR POLICE OFFICERS. $1.15 each or $95 per C.
- ☐ SOME THINGS YOU SHOULD KNOW ABOUT MENTAL AND EMOTIONAL ILLNESS. $2.00 per C; $16.35 per M.
- ☐ WHAT EVERY CHILD NEEDS FOR GOOD MENTAL HEALTH. $1.35 per M.
- ☐ WHEN THINGS GO WRONG. $9.00 per C.
- ☐ MENTAL ILLNESS: A GUIDE FOR THE FAMILY (revised edition). 80¢ each. Handbook for families of the mentally ill.
- ☐ NAMH PUBLICATIONS CATALOG. Free.
- ☐ WHERE YOU CAN FIND INFORMATION ON MENTAL HEALTH AND MENTAL ILLNESS: A BIBLIOGRAPHY. $2.25 per C.

Joint Information Service Publications

- ☐ CHILDREN AND MENTAL HEALTH CENTERS. $6.00 each.
- ☐ ELEVEN INDICES. $4.00 each.
- ☐ HALFWAY HOUSES FOR THE MENTALLY ILL. $6.00 each
- ☐ MENTAL HEALTH ON THE CAMPUS: A FIELD REPORT. $7.50 each.
- ☐ HEALTH INSURANCE FOR MENTAL ILLNESS. $2.50 each.
- ☐ PARTIAL HOSPITALIZATION FOR THE MENTALLY ILL: A STUDY OF PROGRAMS AND PROBLEMS. Cloth: $6.00 each; 4 or more copies $5.25 each. Paper: $4.00 each; 4 or more copies $3.50.
- ☐ PRIVATE PSYCHIATRIC HOSPITALS: A NATIONAL SURVEY. $3.00 each.
- ☐ REHABILITATING THE MENTALLY ILL IN THE COMMUNITY. $6.00 each.
- ☐ THE COMMUNITY MENTAL HEALTH CENTER: AN INTERIM APPRAISAL. Cloth: $6.50 each; 4 or more copies $5.25 each. Paper: $4.00 each; 4 or more copies $3.50.
- ☐ THE MENTALLY ILL OFFENDER: A SURVEY OF TREATMENT PROGRAMS. Patricia K. Scheidemandel and Charles K. Kanno. $2.00 each.
- ☐ THE PSYCHIATRIC EMERGENCY: A STUDY OF PATTERNS OF SERVICE, 1966. $2.50 each; 5 or more copies $2.00 each.
- ☐ SALARY RANGES OF PERSONNEL EMPLOYED IN STATE MENTAL HOSPITALS AND COMMUNITY MENTAL HEALTH CENTERS, 1970. Patricia L. Scheidemandel and Charles K. Kanno. $4.00 each.
- ☐ LEGAL SERVICES AND COMMUNITY MENTAL HEALTH CENTERS. Henry Weihofen. $2.00 each.
- ☐ THE STAFF OF THE MENTAL HEALTH CENTER: A FIELD STUDY. Hardcover: $6.00 each; 4–9 copies $5.25; 10 or more copies $4.75 each.
- ☐ THE TREATMENT OF ALCOHOLISM. $3.00 each.
- ☐ TREATMENT OF DRUG ABUSE: A STUDY OF PROGRAMS AND PROBLEMS. $7.00 each.

(Bulk orders available from Publications Department, American Psychiatric Association, 1700 18th St., N.W., Washington, D.C. 20009. Discount for bulk orders.) The Joint Information Service is sponsored by the National Association for Mental Health and the American Psychiatric Association.

THE NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.

Founded by Cli[illegible] W. Beers in 1909, the National Association for Mental Health is a voluntary citizens' organi[illegible]n working for the improved care and treatment of the mentally ill, for improved methods and s[illegible] in research, prevention, detection, diagnosis and treatment of mental illness and for the promo[illegible] mental health.

2-8-11
75

If you didn't make it last year . . .

Make plans now to attend the Mental Health Association's 1974 Annual Meeting in Washington, D.C., November 20-23. Your being there will help make a difference, so . . .